Meaningful User Guide

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Steps to Becoming a Meaningful User

Now that you have decided to participate in the government's meaningful use program there are some steps you have to take to successfully meet the requirements they have provided. The list below are the bare minimum steps, but this guide will assist you in further detail to setup your ChiroWrite system to achieve the program goals. ChiroWrite does the calculations for you to enter in online, but attestation is the sole responsibility of the eligible professional. Good luck and let us know if you have additional questions by calling our office at 800-642-6082.

1. Successfully register for the Medicare EHR Incentive Program.

2. Meet meaningful use criteria using certified EHR technology.

3. Successfully attest, using the CMS Web-based system, that you have met meaningful use criteria using certified EHR technology.

Security and Encryption

ChiroWrite uses a SHA-1 hashing algorithm at 160-bits to check the integrity of information. This assists in determining if information has been altered prior to receipt. ChiroWrite also uses the Advanced Encryption Standard (AES) which is a symmetric-key encryption in a 128-bit block used to safeguard information. ChiroWrite uses the CBC cipher mode and encodes the information using HEX codes.

Registration

1. Successfully register for the Medicare EHR Incentive Program.

For more information about registration please click the link below

http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp

Registration site, please click the link below

https://ehrincentives.cms.gov/hitech/login.action

CMS EHR Certification ID

Request the "CMS EHR Certification ID" for ChiroWrite you will need this during the attestation process, but not necessarily during the registration process.

1. Visit the Certified Health IT Product List http://onc-chpl.force.com/ehrcert/
2. Choose Ambulatory Practice Type
3. Search for ChiroWrite
4. Add ChiroWrite to your cart and then click on Get CMS EHR Certification ID

View the video created by CMS to assist you with the Registration process
http://www.homefront.tv/media/I0436/video/I0436_EHR_FC_2011_0103.wmv

You can also use the User Registration Guide created by CMS to assist you with registration
http://www.cms.gov/EHRIncentivePrograms/Downloads/EHRMedicareEP_RegistrationUserGuide.pdf

Stage 1: Core Measures

The core measures are ones that are required to be completed by the incentive program. All 15 measures must be attested to and calculations must be performed. ChiroWrite does the calculations for you, but attestation online is the sole responsibility of the eligible professional. Remember that there are also 10 menu measures of which 5 need to be chosen. In total, you must complete 20 measures to qualify for the incentive payment.

The measures describe all calculations as for unique patients. A unique patient is described as a patient who has had at least one face-to-face meeting with the eligible provider. If the patient has been seen multiple times, they are only counted once in the calculations.

Core Measures

Computer Provider Order Entry (CPOE)
Drug-Drug and Drug-Allergy Checks
Problem List
e-Prescribing
Active Medication List
Active Medication Allergy List
Record Demographics
Record Vital Signs
Record Smoking Status
Clinical Quality Measures
Clinical Decision Support Rule
Electronic Copy of Health Information
Clinical Summaries
Electronic Exchange of Clinical Information
Protect Electronic Health Information

If you still are a bit confused about the measures and how they are viewed in the Meaningful Use Statistics

area CLICK HERE to view additional guides that may provide you with a different view or better visual picture.

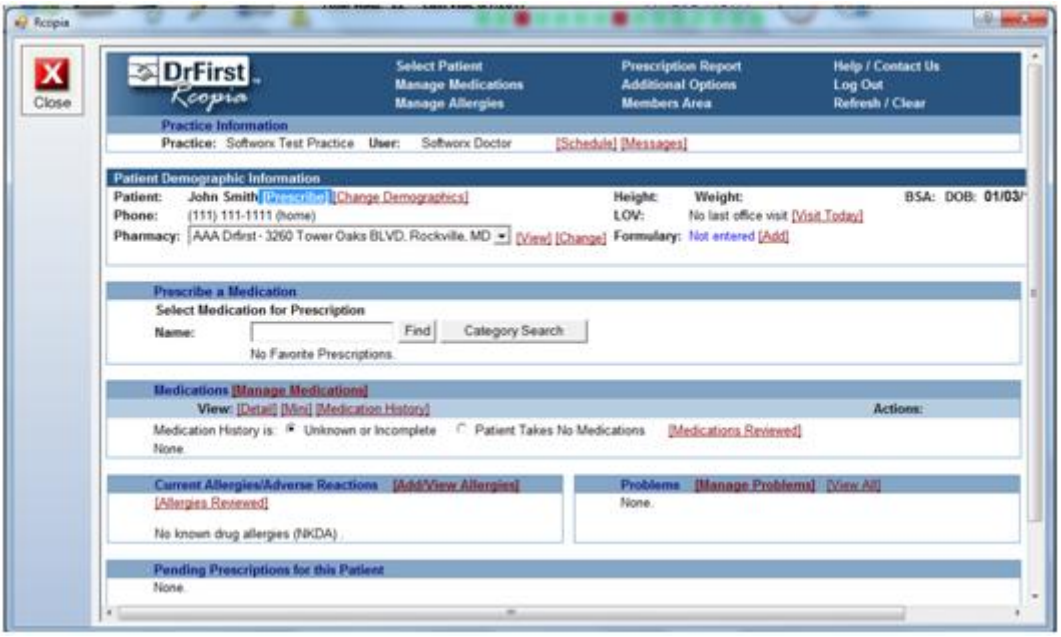
Computer Provider Order Entry (CPOE)

If you are writing prescriptions, you must use your EHR to order the medication for more than 30 percent of all unique patients.

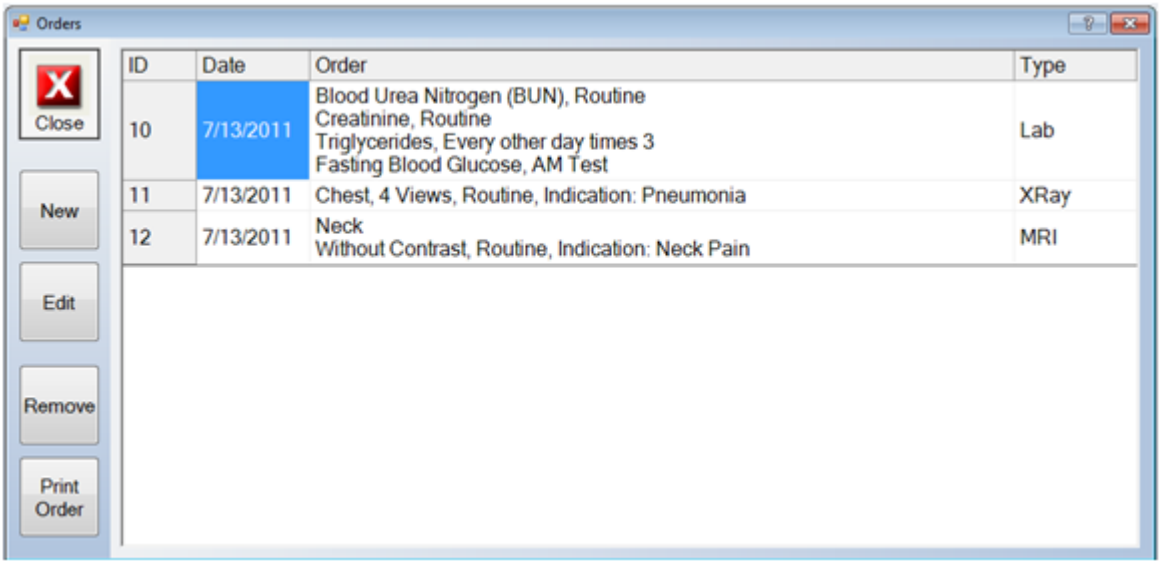
You can be excluded if, you write less than 100 prescriptions during the reporting period.

If you are excluded you must enter the number of prescriptions written during the EHR reporting period in the Exclusion box to attest to exclusion from this requirement.

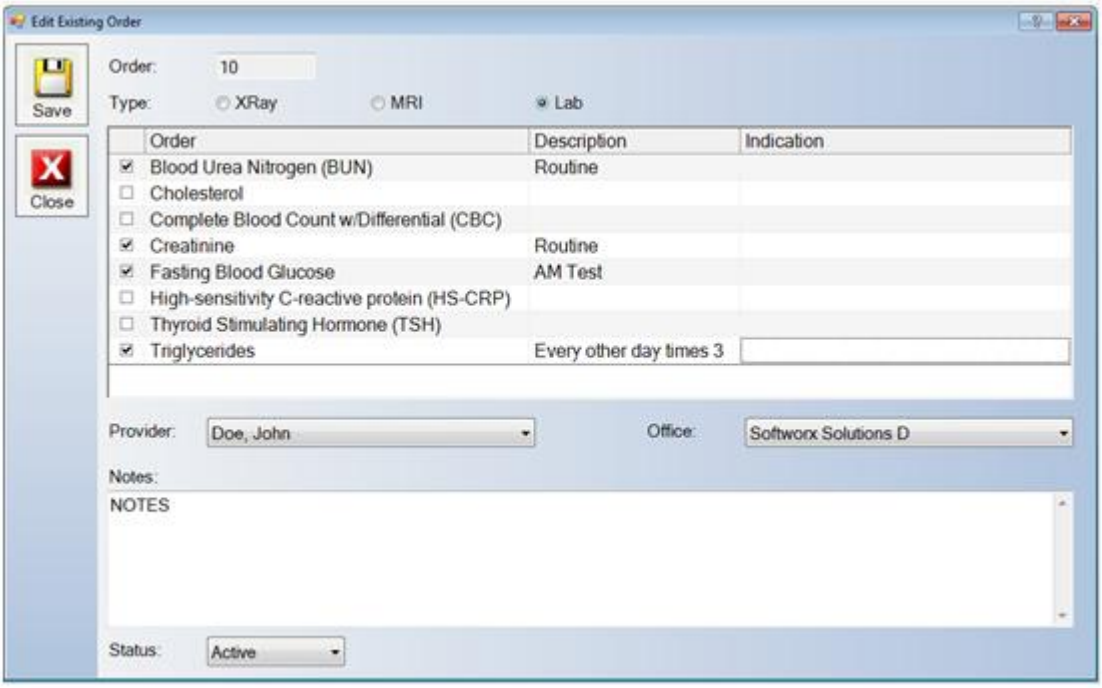
Prescriptions for medications can be written by navigating to Patient Activities > Patient Medications and click on the manage button, this will take you to Rcopia. Once here, click on Prescribe just to the right of your patient's name. At this point you can begin prescribing medications and order them by sending to your patient's preferred pharmacy. Just be sure that a pharmacy is selected for your patient.



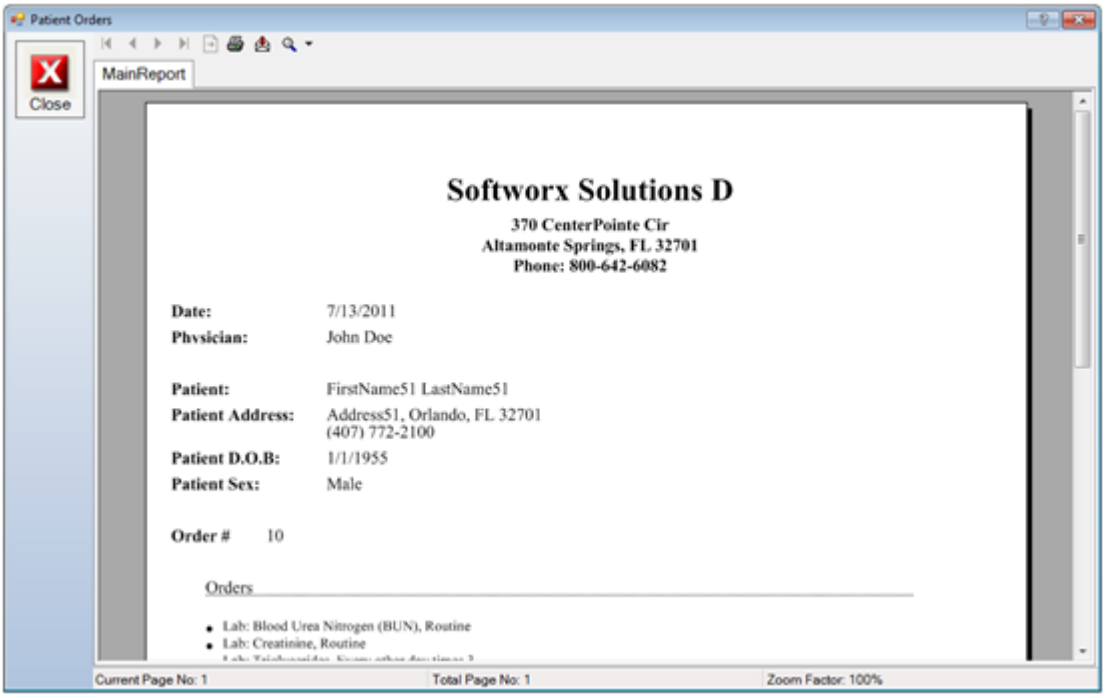
Prescriptions for Labs, an MRI or an X-Ray will be written by navigating to Patient Activities > Orders.



Click New to create a new order, edit to change and existing order, remove to delete an order and Print Order to print the order.



In creating a new order or editing an existing order, you will be choosing from options that you already setup under the Administration section. Checks in the check box mean that you are selecting that item to show up in the order. Be sure to select which provider is creating the order and the office it it being written from. The notes section allows you to type additional information should you need it. Click Save when finished and then close.

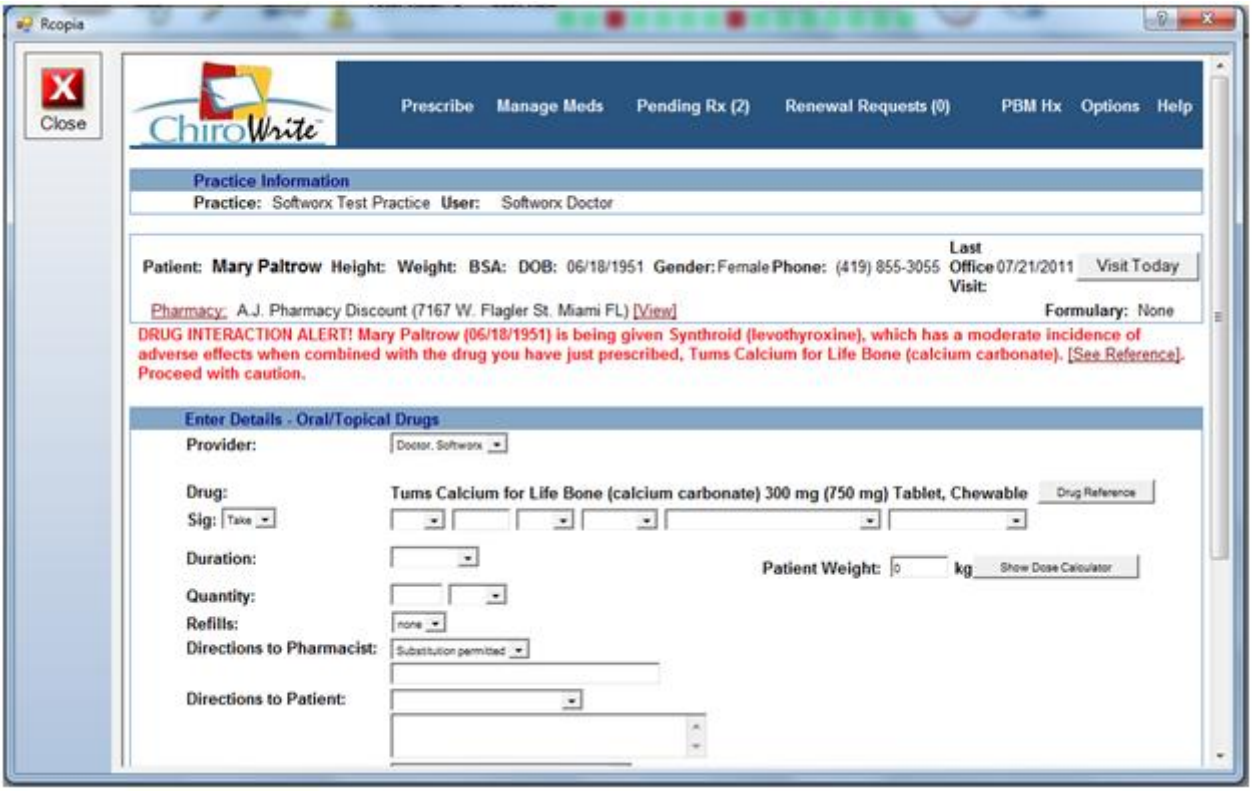


Drug Interaction Checks

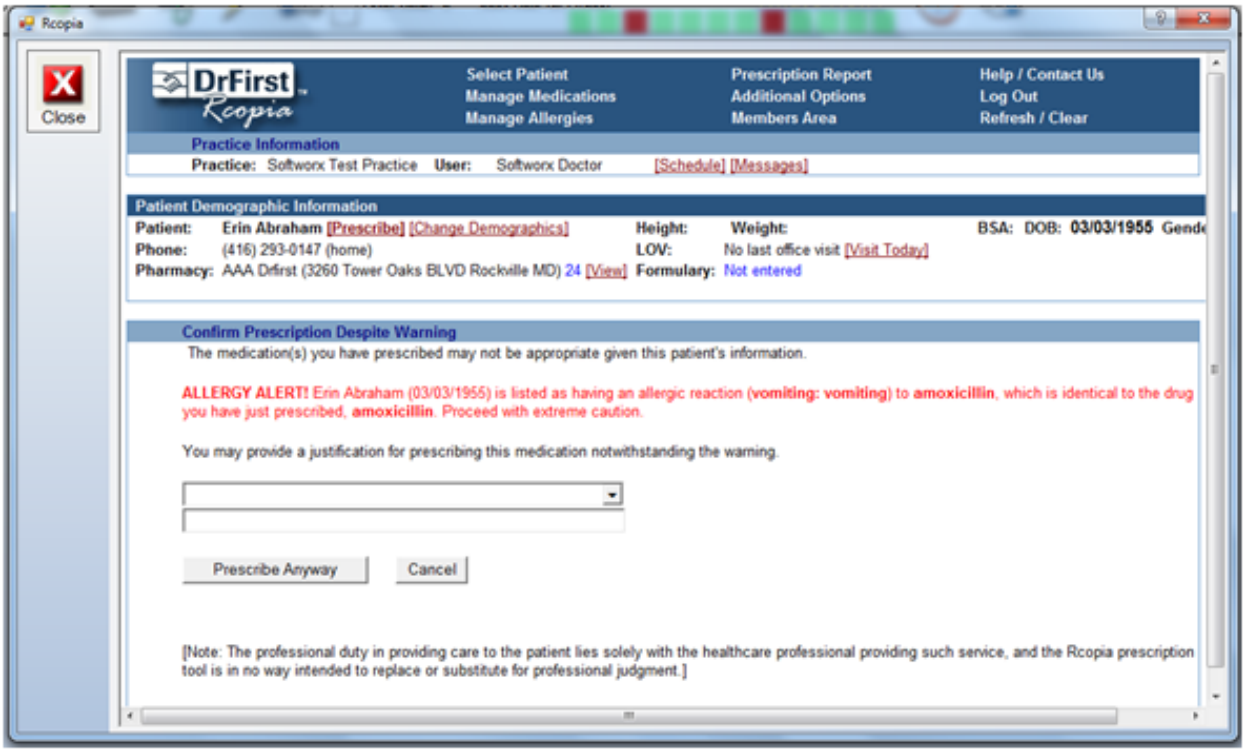
You must attest yes to this measure. There are no exclusions. You must be entering in your patient's medications that they take and any medications that they may have an allergy to so that problems between medications or allergies to medications can be assessed.

This is done through ChiroWrite and Rcopia where medications and allergies to medications are input. Should an individual be allergic to a specific medication and they are prescribed this medication or they are taking a medication and they are above a certain age then the doctor will be immediately notified of the interaction or the possibility for an interaction. You will be alerted immediately and it may look like the ones shown below. If you are still not sure what to do or just cannot remember how to put in patient medications, please view the Drug Interaction Checks.

Drug-Drug Interaction


Rcopia
Close
ChiroWrite
Prescribe
Manage Meds
Pending Rx (2)
Renewal Requests (0)
PBM Hx
Options
Help
Practice Information
Practice: Softworx Test Practice User: Softworx Doctor
Patient: Mary Paltrow Height: Weight: BSA: DOB: 06/18/1951 Gender: Female Phone: (419) 855-3055
Last Office Visit: 07/21/2011
Visit Today
Pharmacy: A.J. Pharmacy Discount (7167 W. Flagler St. Miami FL) [View]
Formulary: None
DRUG INTERACTION ALERT! Mary Paltrow (06/18/1951) is being given Synthroid (levothyroxine), which has a moderate incidence of adverse effects when combined with the drug you have just prescribed, Tums Calcium for Life Bone (calcium carbonate). [See Reference]. Proceed with caution.
Enter Details - Oral/Topical Drugs
Provider:
Drug:
Tums Calcium for Life Bone (calcium carbonate) 300 mg (750 mg) Tablet, Chewable
Drug Reference
Sig:
Duration:
Patient Weight:
kg
Show Dose Calculator
Quantity:
Refills:
Directions to Pharmacist:
Substitution permitted
Directions to Patient:

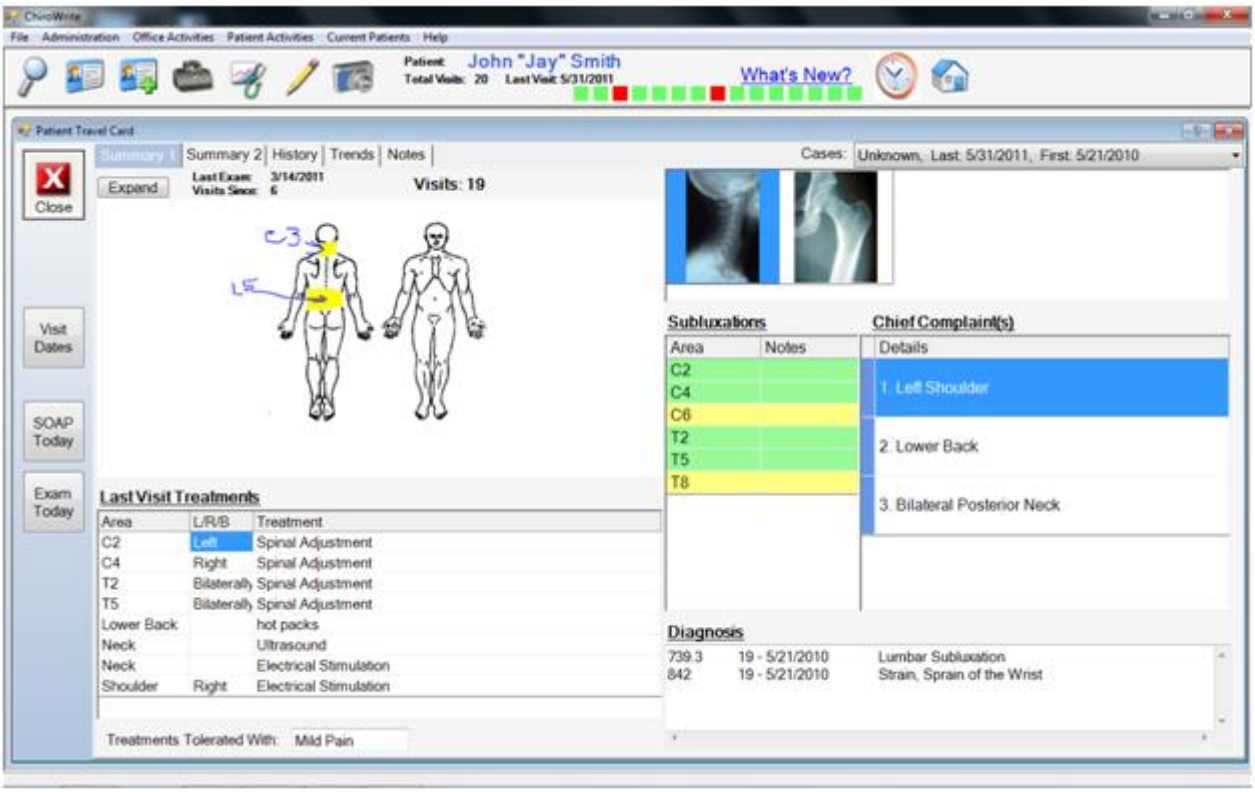
Drug-Allergy Interaction


Rcopia
Close
DrFirst
Rcopia
Select Patient
Manage Medications
Manage Allergies
Prescription Report
Additional Options
Members Area
Help / Contact Us
Log Out
Refresh / Clear
Practice Information
Practice: Softworx Test Practice User: Softworx Doctor
[Schedule] [Messages]
Patient Demographic Information
Patient: Erin Abraham [Prescribe] [Change Demographics]
Height: Weight: BSA: DOB: 03/03/1955
Phone: (416) 293-0147 (home)
LOV: No last office visit [Visit Today]
Pharmacy: AAA Drfirst (3260 Tower Oaks BLVD Rockville MD) 24 [View]
Formulary: Not entered
Confirm Prescription Despite Warning
The medication(s) you have prescribed may not be appropriate given this patient's information.
ALLERGY ALERT! Erin Abraham (03/03/1955) is listed as having an allergic reaction (vomiting: vomiting) to amoxicillin, which is identical to the drug you have just prescribed, amoxicillin. Proceed with extreme caution.
You may provide a justification for prescribing this medication notwithstanding the warning.
Prescribe Anyway
Cancel
[Note: The professional duty in providing care to the patient lies solely with the healthcare professional providing such service, and the Rcopia prescription tool is in no way intended to replace or substitute for professional judgment.]

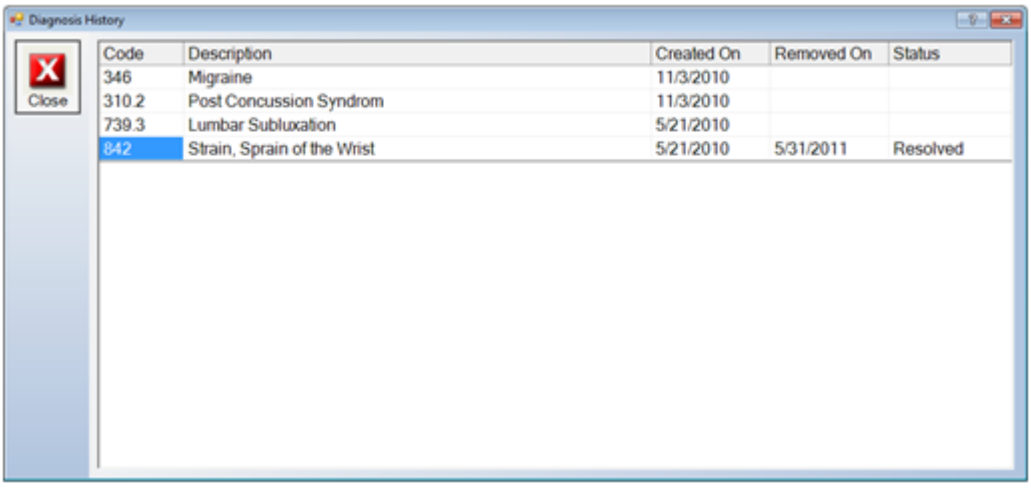
Problem List

You must have at least one entry for more than 80 percent of all unique patients. This means that a list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient must be recorded. So if you see 100 patients during the reporting period than at a minimum 81 of those patients should have a diagnosis recorded.

A patient's current and active diagnosis can always be found on the travel card in the bottom right hand corner.



Should you want to know about the patient's diagnosis history click on Patient Activities > Diagnosis History and you can view diagnosis codes that were used in the past for this particular patient. You can view diagnoses that have been resolved, entered by mistake or were made inactive. If you are still not sure what to do or just cannot remember how to put in patient medications, please view the [Problem List](#).

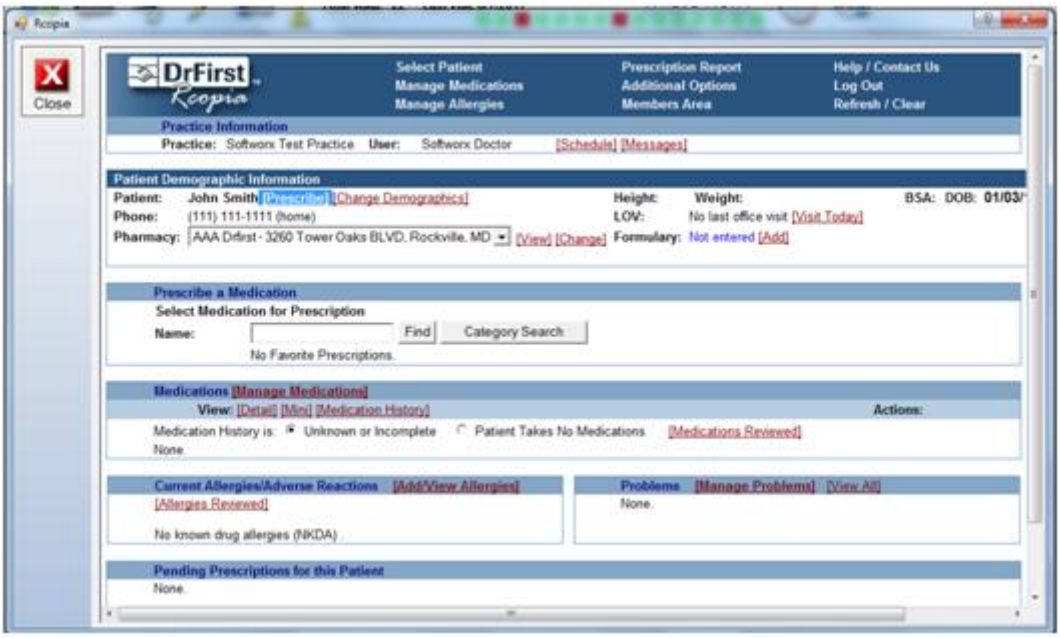

Diagnosis History
Close
Code Description Created On Removed On Status
346 Migraine 11/3/2010
310.2 Post Concussion Syndrom 11/3/2010
739.3 Lumbar Subluxation 5/21/2010
842 Strain, Sprain of the Wrist 5/21/2010 5/31/2011 Resolved

e-Prescribing

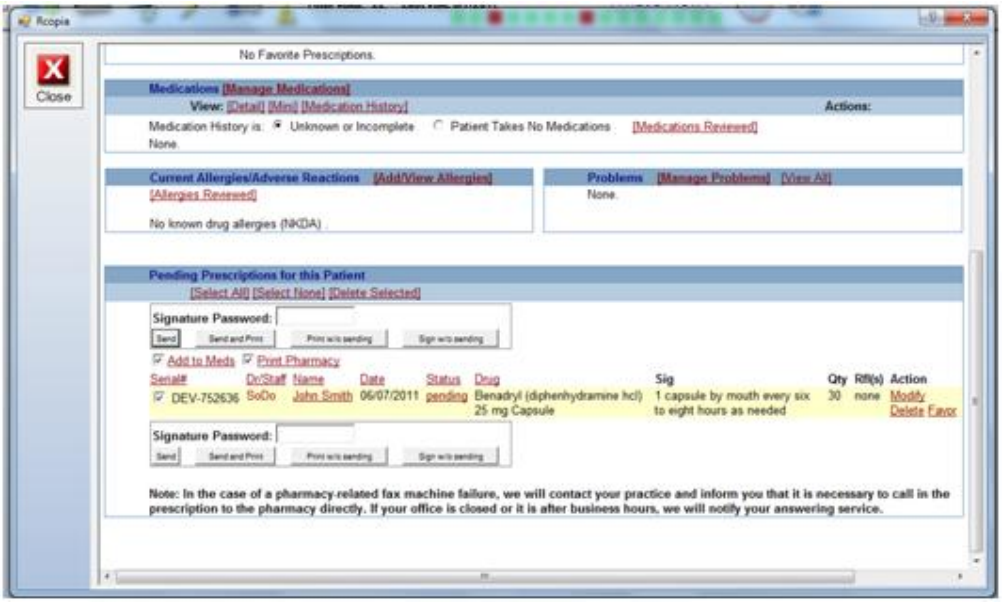
If you are writing prescriptions, you must use your EHR to generate and transmit permissible prescriptions for more than 40 percent of all unique patients. So if you see 100 patients during the reporting period than at a minimum 41 of those patients should have a prescription that was done electronically using Rcopia.

You can be excluded if, you write less than 100 prescriptions during the reporting period. If you are excluded you must enter the number of prescriptions written during the EHR reporting period in the Exclusion box to attest to exclusion from this requirement.

This is done through ChiroWrite and Rcopia where a patient's medications as well as allergies to medications can be entered. By navigating to the patient you want to work with and clicking Patient Activities > Patient Medications you will be taken to Rcopia where you can begin entering the medications you want to prescribe your patient. Be sure to click the prescribe button just to the right of your patient's name. For additional information, please review the Rcopia Help Section, specifically the Prescription Writing Section.



Remember you have to sign and send your prescriptions to the pharmacy of your patient's choice.

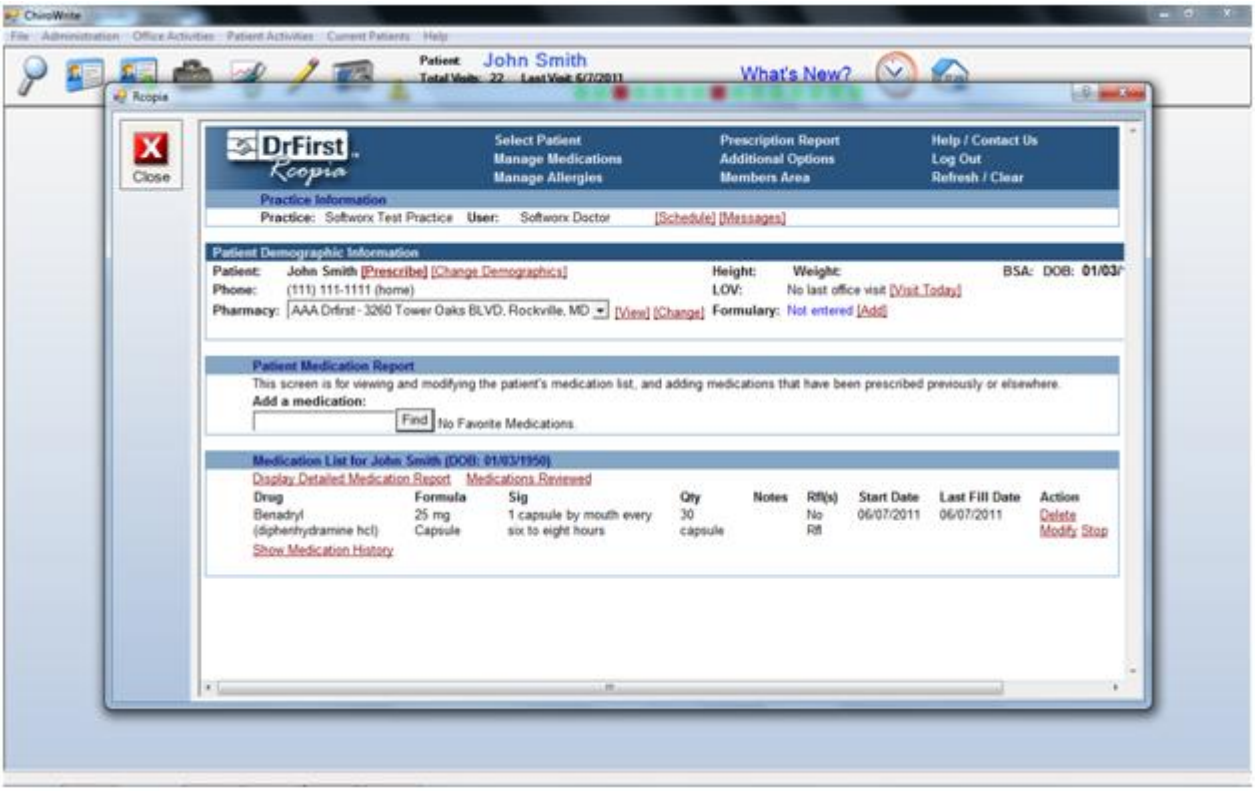

Close
No Favorite Prescriptions.
Medications [Manage Medications]
View: [Detail] [Mini] [Medication History] Actions:
Medication History is: Unknown or Incomplete Patient Takes No Medications [Medications Reviewed]
None.
Current Allergies/Adverse Reactions [Add/View Allergies]
[Allergies Reviewed]
No known drug allergies (NKDA)
Problems [Manage Problems] [View All]
None.
Pending Prescriptions for this Patient
[Select All] [Select None] [Delete Selected]
Signature Password:
Send Send and Print Print w/o sending Sign w/o sending
Add to Meds Print Pharmacy
Serial# Dr/Staff Name Date Status Drug Sig Qty Rfl(s) Action
DEV-752636 SoDo John Smith 06/07/2011 pending Benadryl (diphenhydramine hcl) 25 mg Capsule 1 capsule by mouth every six to eight hours as needed 30 none Modify Delete Favor
Signature Password:
Send Send and Print Print w/o sending Sign w/o sending
Note: In the case of a pharmacy-related fax machine failure, we will contact your practice and inform you that it is necessary to call in the prescription to the pharmacy directly. If your office is closed or it is after business hours, we will notify your answering service.

Maintain Active Medication List

You must keep a current list of any and all active medications that a patient is currently taking.

You must have at least one entry or an indication that a patient is not currently prescribed any medication for more than 80 percent of all unique patients. There are no exclusions. So if you see 100 patients during the reporting period than at a minimum 81 of those patients should have medications that they are currently taking entered into their file.

This is done through ChiroWrite and Rcopia where medications can be input. Click on Patient Activities > Patient Medications > Manage to launch Rcopia and click on Manage Medications to begin adding and editing a patient's medication list. For additional information, please review the Rcopia Help Section, specifically the Entering a Medication Section. If you are still not sure what to do or just cannot remember how to put in patient medications, please view the Patient Medications Video.



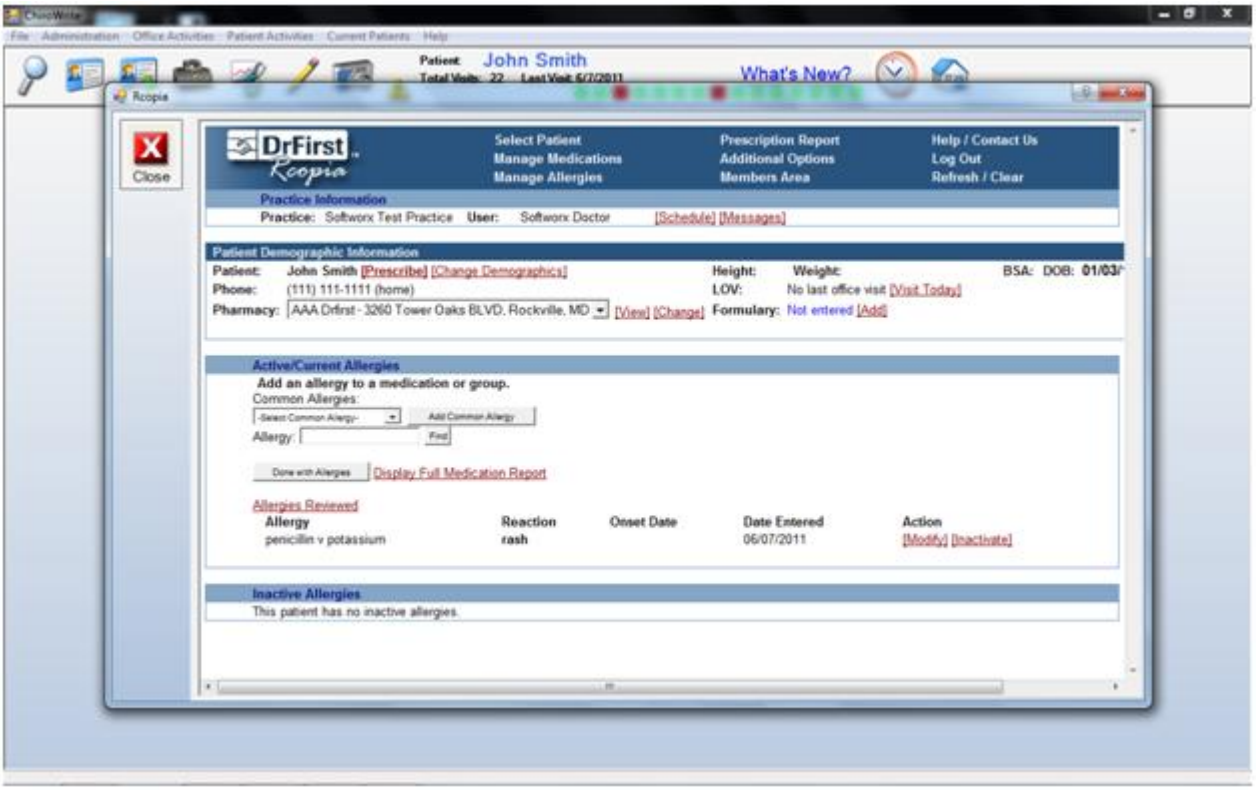
Maintain Active Medication Allergy List

You must keep a current list of any and all medications to which a given patient has known allergies.

You must have at least one entry or an indication that a patient currently has no known allergies for more than 80 percent of all unique patients. There are no exclusions. So if you see 100 patients during the reporting period than at a minimum 81 of those patients should have allergies to medications entered into their file.

This is done through ChiroWrite and Rcopia where medication allergies can be input. Click on Patient Activities > Patient Allergies> Manage to launch Rcopia and click on Manage Allergies to begin adding and editing a patient's medication allergy list. For additional information, please review the Rcopia Help Section, specifically the Entering an Allergy Section. If you are still not sure what to do or just cannot remember how to put in patient medications, please view the Medication Allergy

***Video*.**



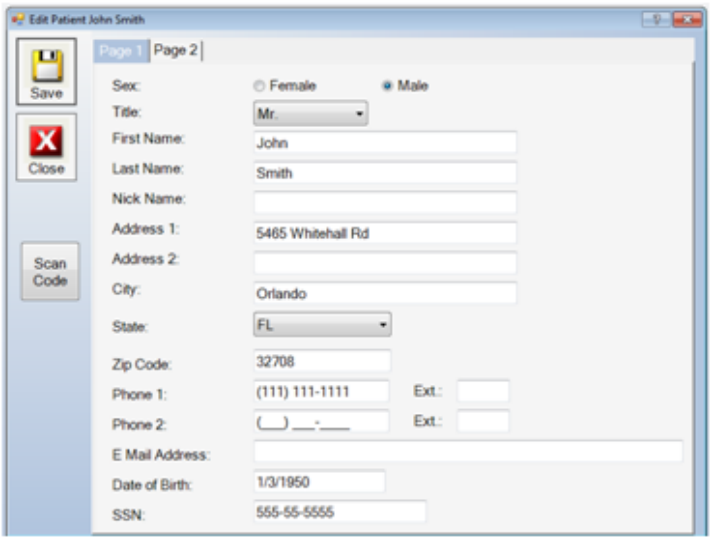
Record Demographics

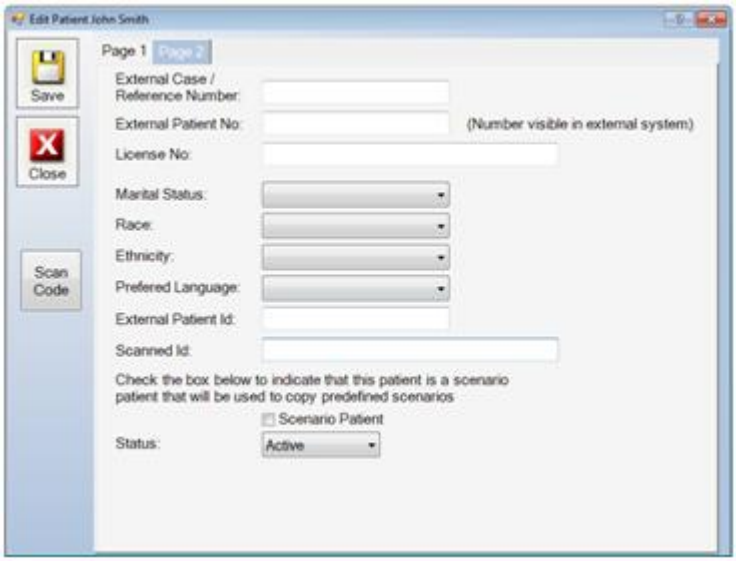
You must record a patient's gender, race, ethnicity, DOB and language by which the patient prefers to communicate for more than 50 percent of all unique patients. You may also select that a patient declined to provide this information. So if you see 100 patients during the reporting period than at a minimum 51 of those patients should have their address, phone number, date of birth, race, ethnicity and preferred language entered into their file. If you need more information watch the video Record Demographics.

There are no exclusions. You are not required to communicate with the patient in their preferred language to meet the measure.

In ChiroWrite, demographics can be recorded in the spaces on page 1 and page 2 provided after you click on the contact card with the green plus.

Note: If you are connected to a billing system, you are going to put the patient in the billing system first and then proceed to edit the patient's information in ChiroWrite to include the patient's race, ethnicity and preferred language. Things like address, telephone number DOB, and SSN should be edited in the billing system.



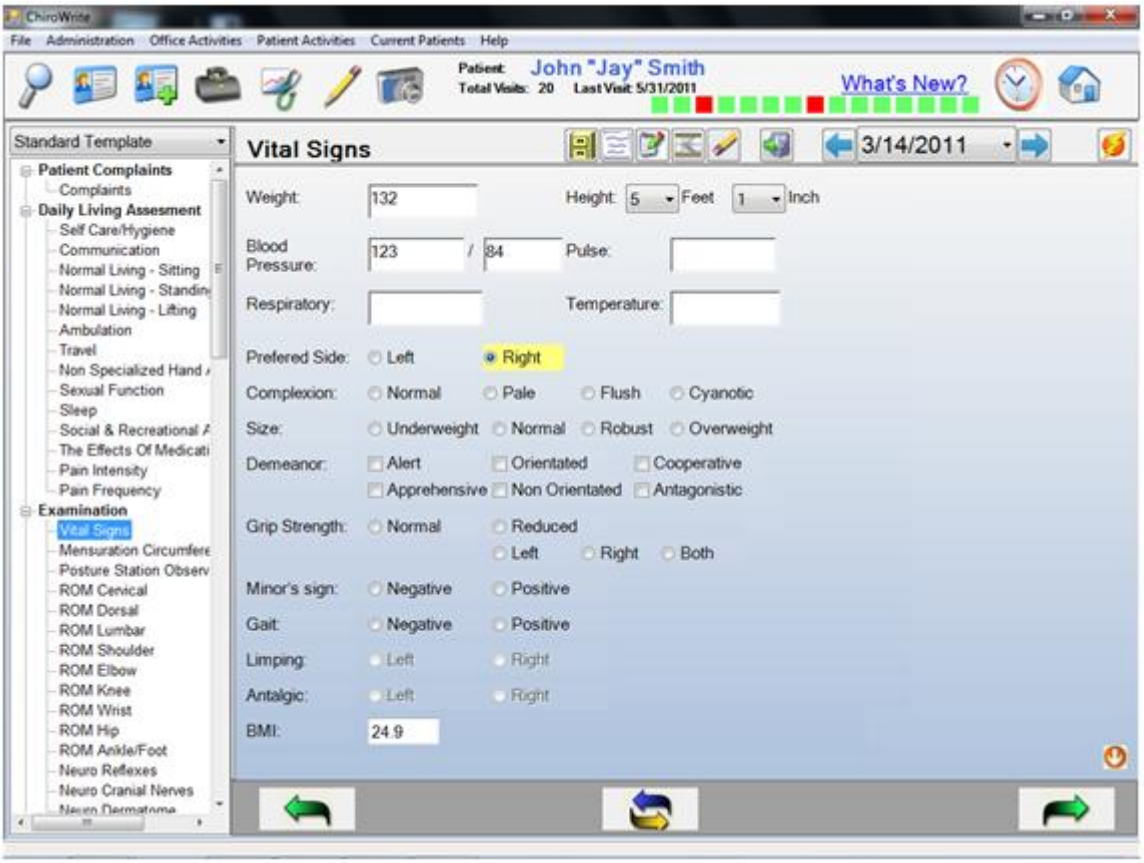


Record Vital Signs

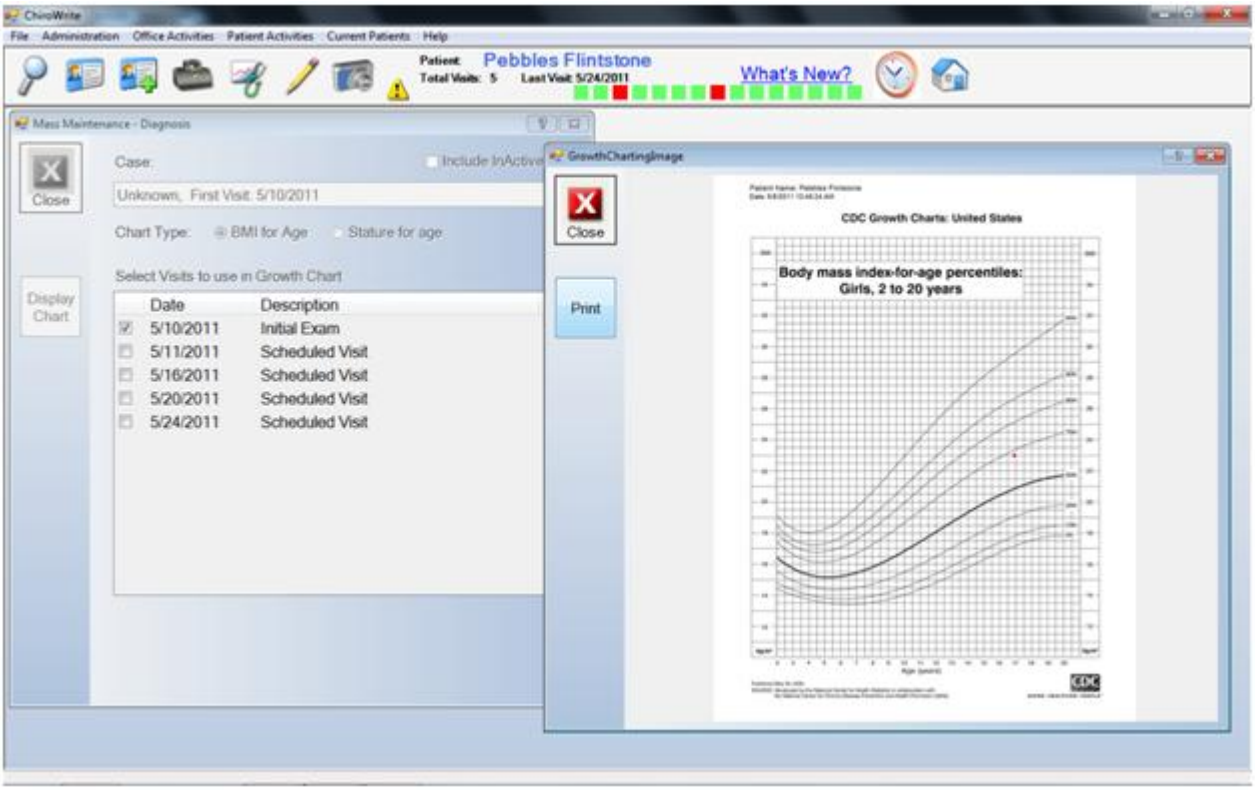
You must record height, weight, blood pressure, calculate and display BMI and plot and display growth charts for children 2-20 years with BMI for more than 50 percent of all unique patients age 2 and over. So if you see 100 patients during the reporting period than at a minimum 51 of those patients who are 2 years old and under should have their height and weight and have a growth chart plotted while patients greater than 2 years old should have height, weight, blood pressure, calculate and a displayed BMI in their file.

You can be excluded, if you see no patients 2 years or older or you believe that all three vital signs of height, weight and blood pressure of your patients has no relevance to your scope of practice.

In ChiroWrite, vital signs can be entered on the vital signs screen found in the examination workflow. BMI will be calculated for you and shown on the bottom part of the screen. You can view the video, if you are still not sure, about Record Vital Signs.

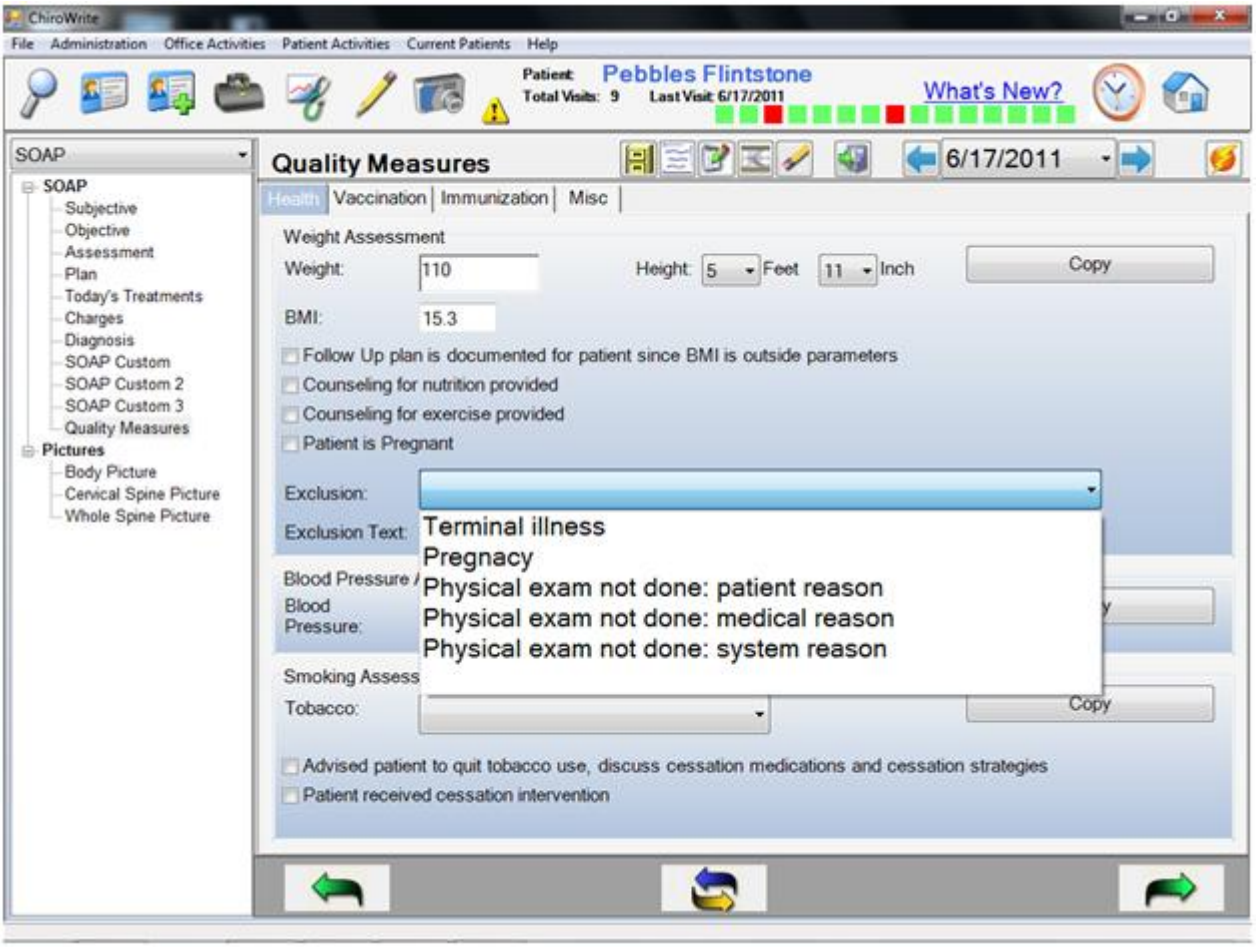


In order to display the growth chart, select the patient you want to run a growth chart for and navigate to Patient Activities > Growth Charts. From this section, you will be able to choose a visit or visits that you would like to graph. You will be able to graph BMI as well as the height and weight proportions for children ages 2-20. Choose the Stature for age option to graph the height and weight proportions. Should you need to print off the graph for any reason, there is a print button on the left hand side of the graph.



You also must navigate to the Quality Measures screen in the worxflow to answer some additional questions about your patient if they are indeed overweight. Have you had nutritional or exercise related discussions with them? Have you created a follow up plan to assist them? You also might have to consider

that your patient might be excluded due to the following reasons in the drop down box provided.

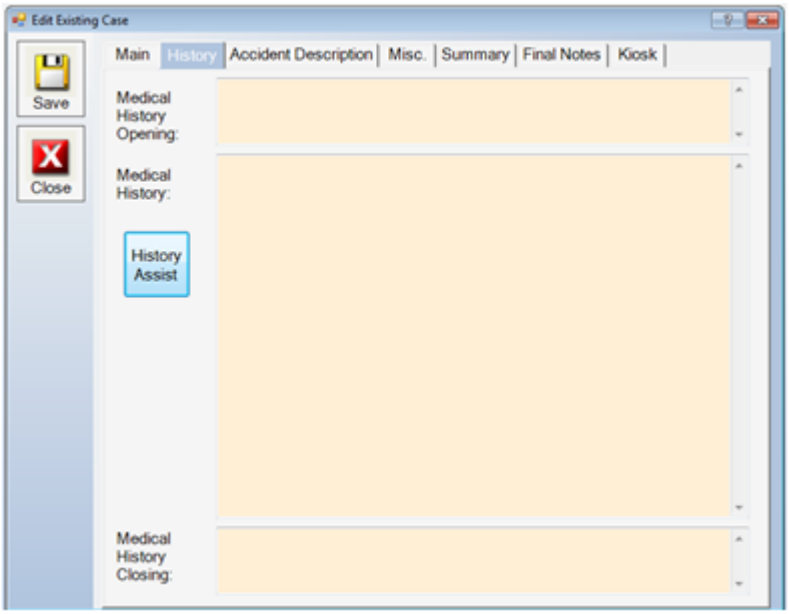


Record Smoking Status

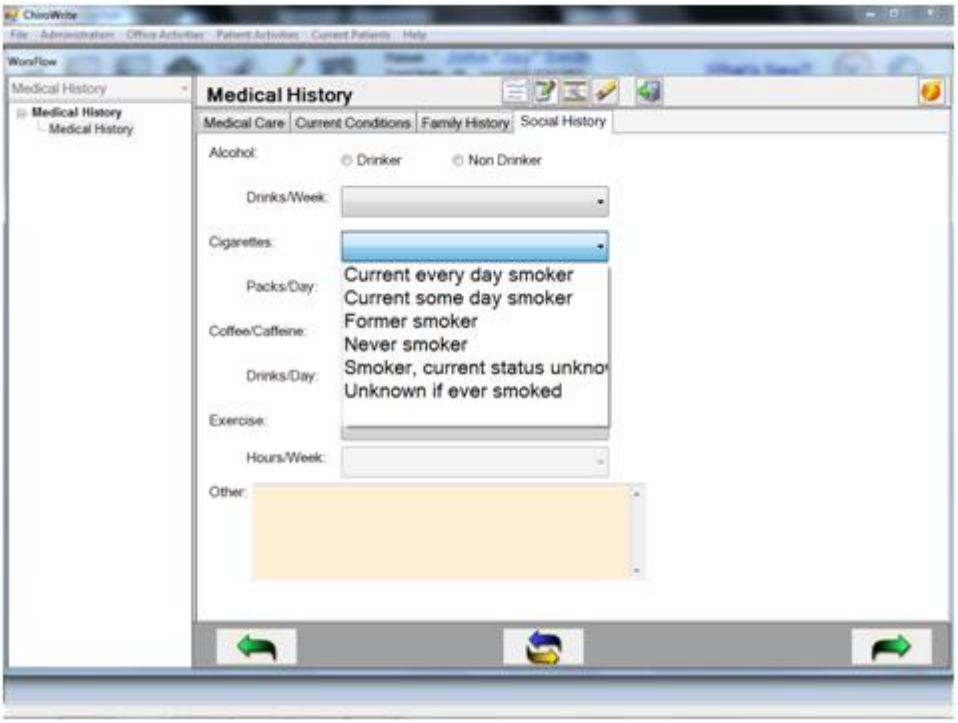
You must record the smoking status for patients 13 years and older for more than 50 percent of all unique patients. So if you see 100 patients during the reporting period that are 13 years and older than at a minimum 51 of those patients should have their smoking status entered into their file. If you need to, you can watch the video on how to [Record Smoking Status](#).

You can be excluded, if you do not see patients 13 years or older.

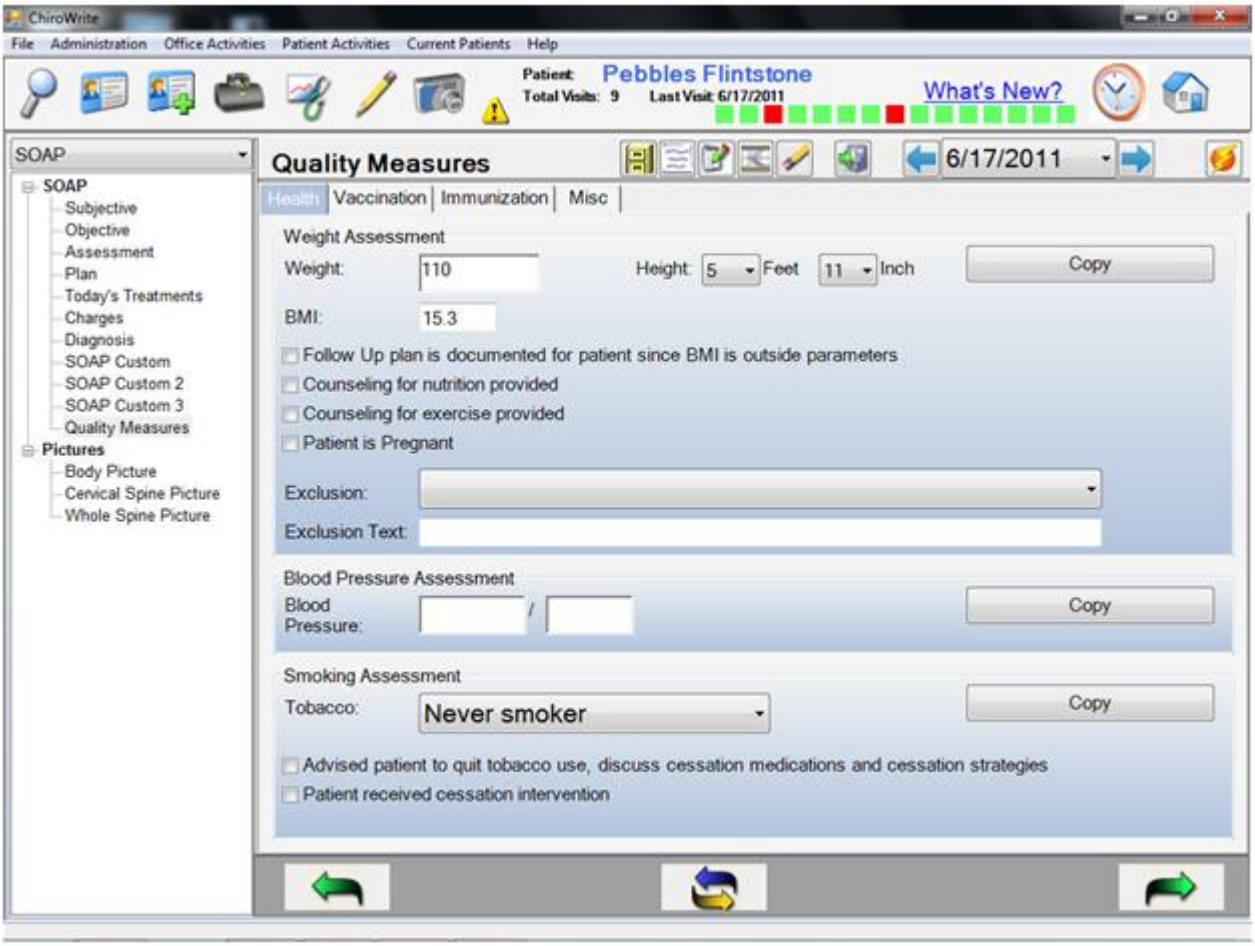
In ChiroWrite, you can enter the patient's smoking status under the Medical History area. Modify the case information by using the yellow filing cabinet ***if you are already in a patient's note or use the doctor's bag*** ***to edit case information if you are not in a note. Once you get into the case information area, click on the history tab and history assist.***



Once in the history assist area shown below, click on the social history tab and make a selection from the drop down box.



You also need to come to the Quality Measures screen in the worxflow and check the following boxes if your patient does smoke. Have you advised them to stop smoking and have you discussed strategies for them to stop smoking? Did they receive an intervention of some kind?



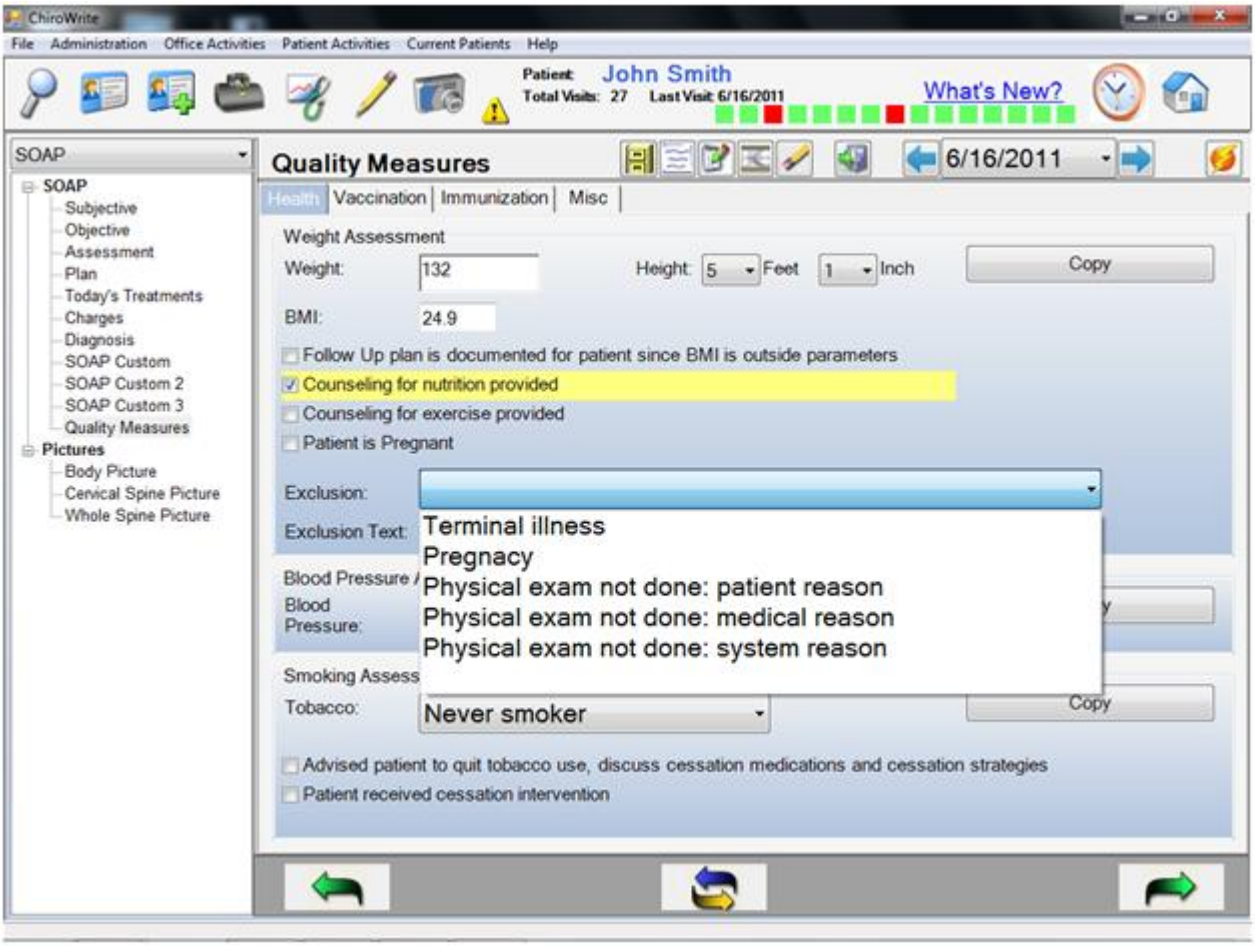
Clinical Quality Measures

You must report ambulatory clinical quality measures to CMS. You must attest yes to this measure. You will be taking the numerators and denominators that ChiroWrite provides you and entering them into the CMS during the attestation process. There are no exclusions. For additional information please watch the [Clinical Quality Measures] video.

Denominator is generally defined as the number of unique patients seen in a face-to-face encounter during the reporting period. Some measures get more specific and define an age limit and so forth.

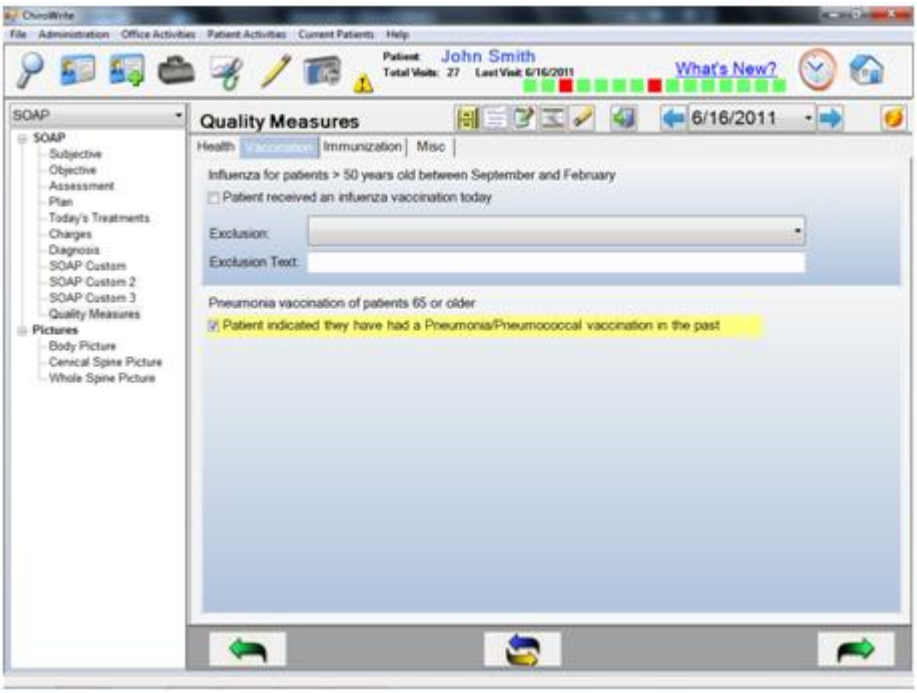
Numerator is generally defined as the number of patients in the denominator who were provided an appropriate action for each measure during the reporting period using the appropriate ChiroWrite workflow.

The Quality Measures screen will assist you in fully completing meaningful use. Such things like speaking to your patient about weight and smoking or taking their blood pressure are important aspects.

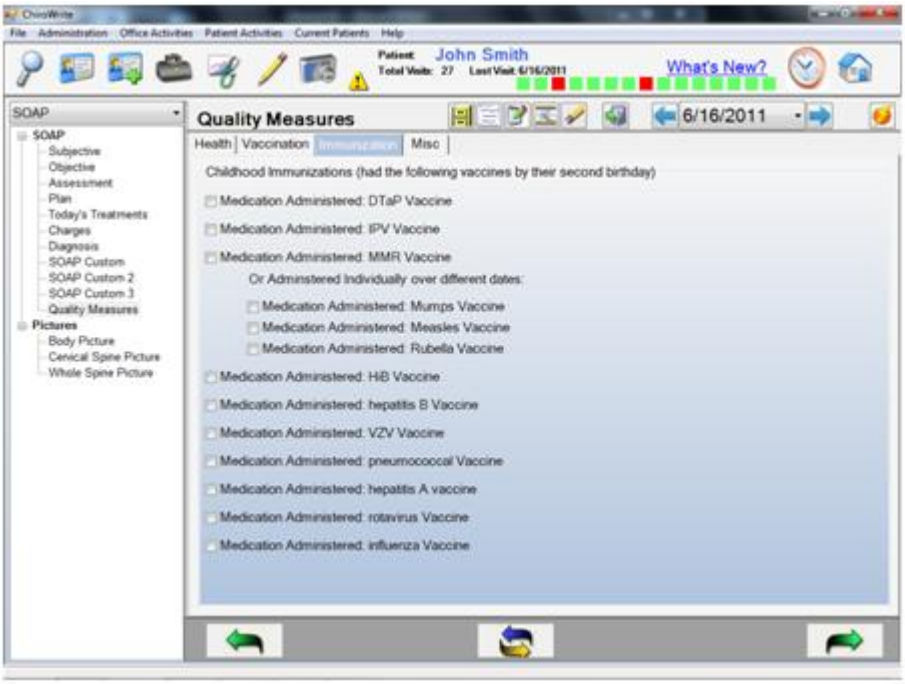


The keeping up with immunizations and vaccinations in the younger and older populations are important for calculations.

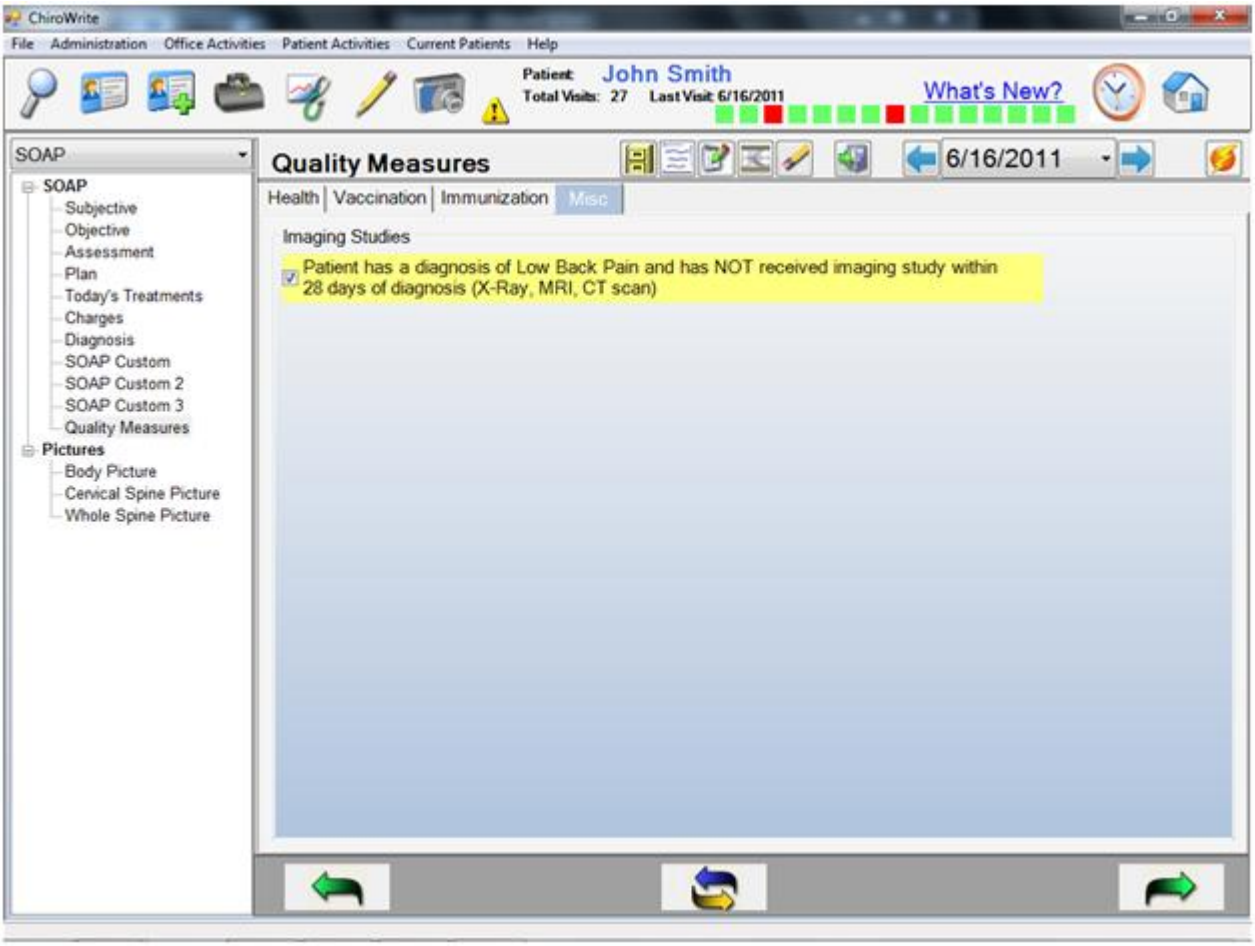
Note: All Chiropractors will probably NOT be giving flu vaccinations so this is a section that may not be filled out.


Quality Measures
6/16/2011
Health Vaccination Immunization Misc
Influenza for patients > 50 years old between September and February
Patient received an influenza vaccination today
Exclusion:
Exclusion Text:
Pneumonia vaccination of patients 65 or older
Patient indicated they have had a Pneumonia/Pneumococcal vaccination in the past

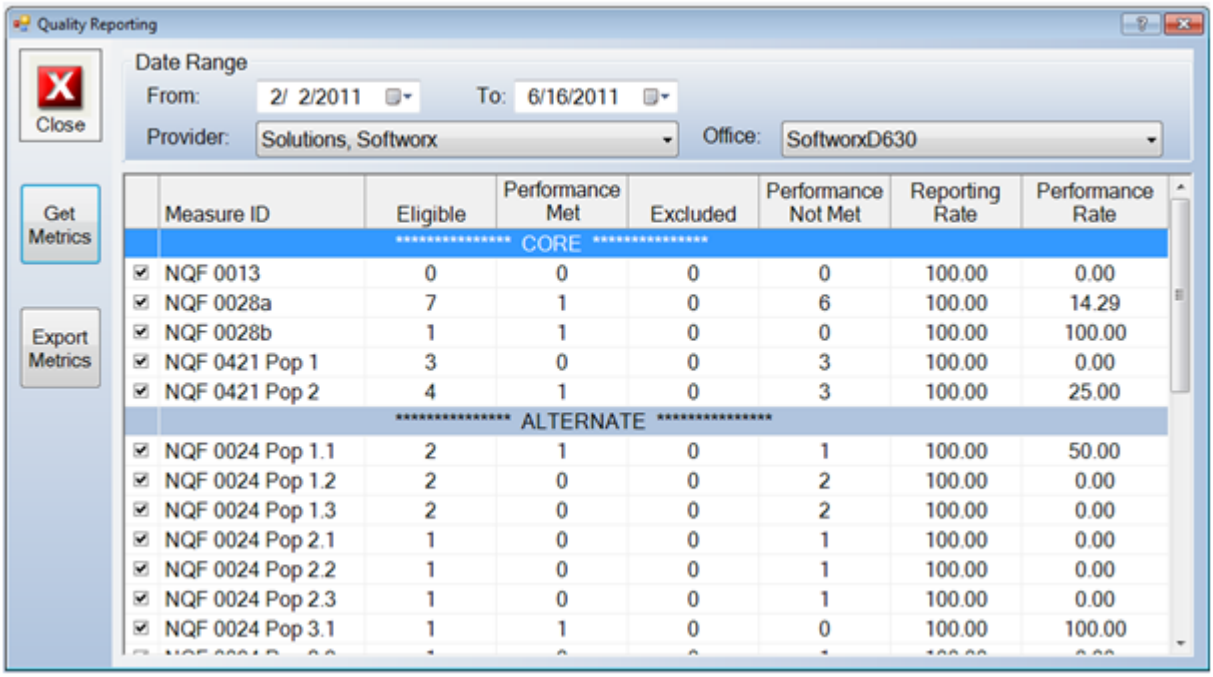
Note: All Chiropractors will probably NOT be giving children immunizations so this is a section that may not be filled out.



Finally, knowing when the imaging studies are performed is also important. Check this only if the patient has not had an imaging study and they have a diagnosis of low back pain.



After inputting information into patient files as shown in the screen shots above as well as other sections of the program, a report can be run to determine if quality measures are being met so that they can successfully be attested to. In order to run this report, navigate to Office Activities > Quality Measures. Set the date range for the amount of time that you wish to run the report for, select the provider and the office and click the Get Metrics button to run the report. The Export Metrics button allows you to save the file to your computer in order to be able to input the PQRI information on the CMS website.

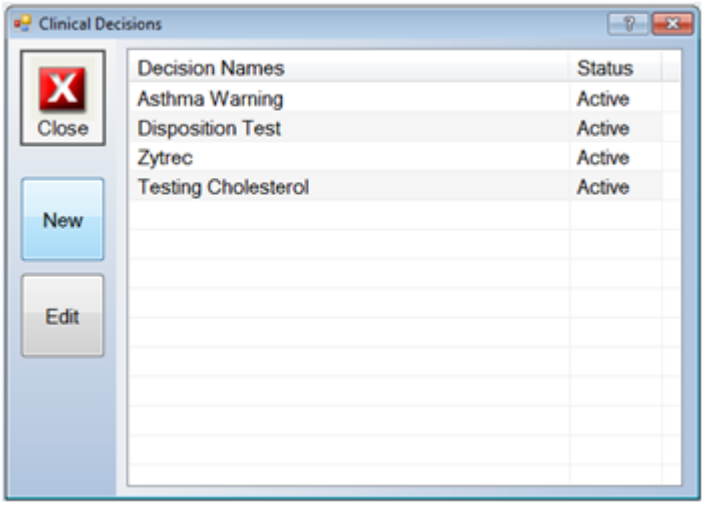

Quality Reporting
Close
Date Range
From: 2/ 2/2011
To: 6/16/2011
Provider: Solutions, Softworx
Office: SoftworxD630
Get Metrics
Export Metrics
Measure ID
Eligible
Performance Met
Excluded
Performance Not Met
Reporting Rate
Performance Rate
********** CORE **********
NQF 0013 0 0 0 0 100.00 0.00
NQF 0028a 7 1 0 6 100.00 14.29
NQF 0028b 1 1 0 0 100.00 100.00
NQF 0421 Pop 1 3 0 0 3 100.00 0.00
NQF 0421 Pop 2 4 1 0 3 100.00 25.00
********** ALTERNATE **********
NQF 0024 Pop 1.1 2 1 0 1 100.00 50.00
NQF 0024 Pop 1.2 2 0 0 2 100.00 0.00
NQF 0024 Pop 1.3 2 0 0 2 100.00 0.00
NQF 0024 Pop 2.1 1 0 0 1 100.00 0.00
NQF 0024 Pop 2.2 1 0 0 1 100.00 0.00
NQF 0024 Pop 2.3 1 0 0 1 100.00 0.00
NQF 0024 Pop 3.1 1 1 0 0 100.00 100.00

Clinical Decision Support Rule

You must implement one clinical decision support rule relevant to your specialty or high clinical priority along with the ability to track compliance with that rule.

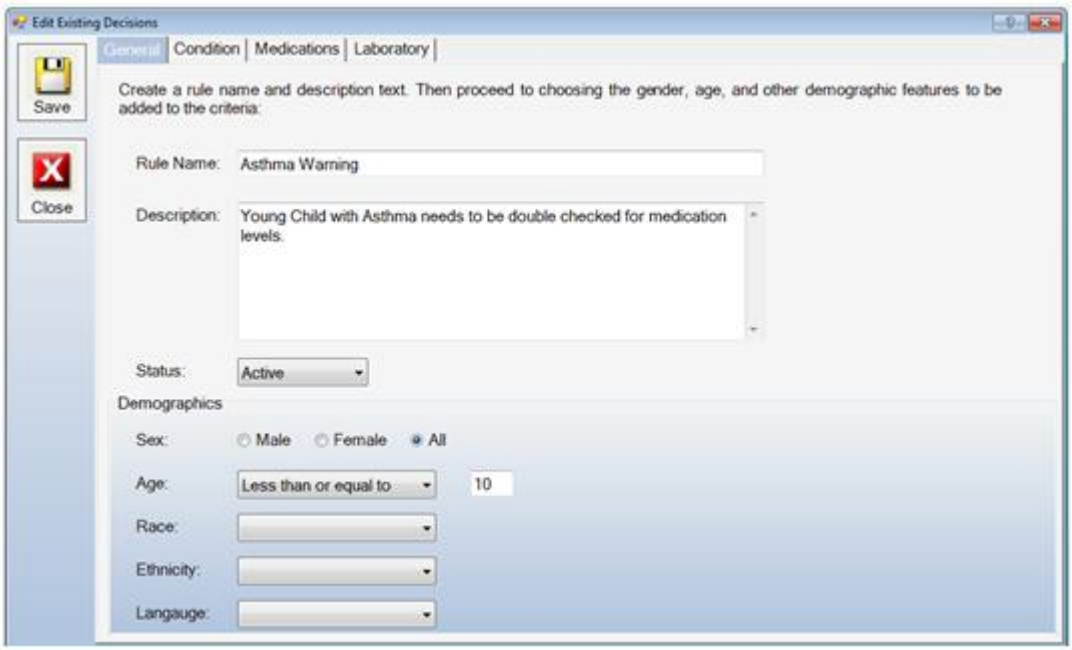
There are no exclusions. You must attest yes to this requirement and the alert has to be over and above the Drug-drug and Drug-allergy interaction alerts found in Rcopia.

In ChiroWrite, to enter in a new decision support rule navigate to Office Activities > Clinical Decisions and click on the new button to create a new decision rule. For additional information please watch the Clinical Decision Support Rule video.

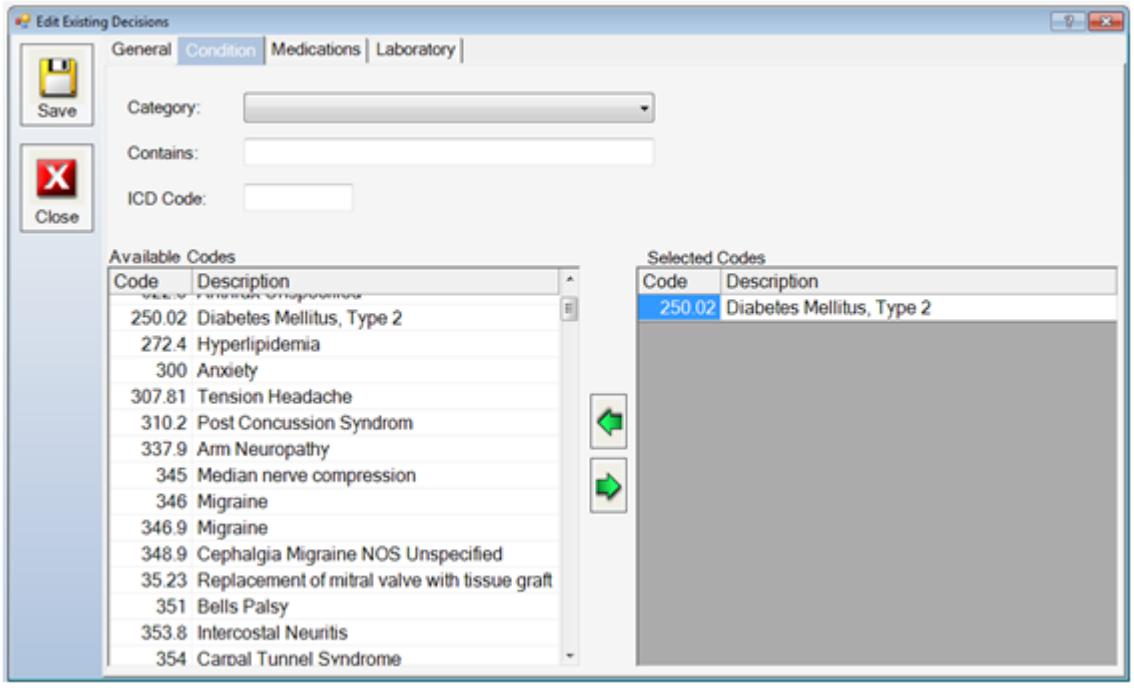


In this particular section, you have several different tabs of decision rules that can be setup. In this particular example, the rule name is an asthma warning for children younger than 10 and the doctor would want to double check the medication levels to be sure the child is doing well. These same kind of decision rules can be setup under the other tabs as well; you could use one tab or multiple tabs. It just depends on

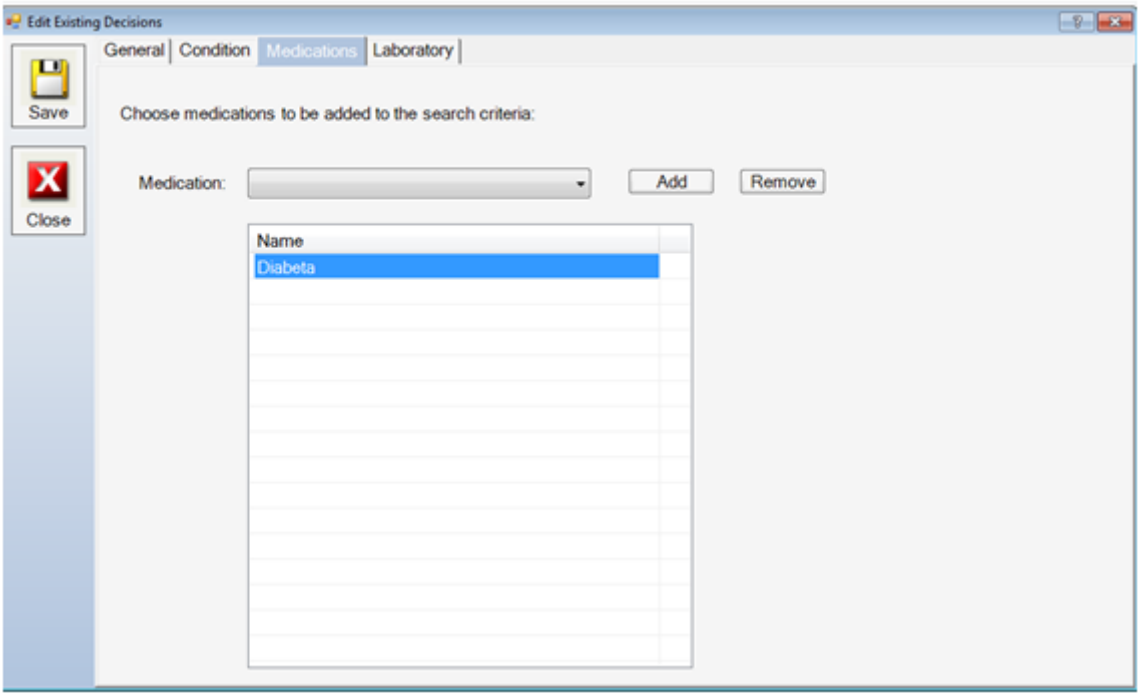
what sort of rules you are looking to add to the system.



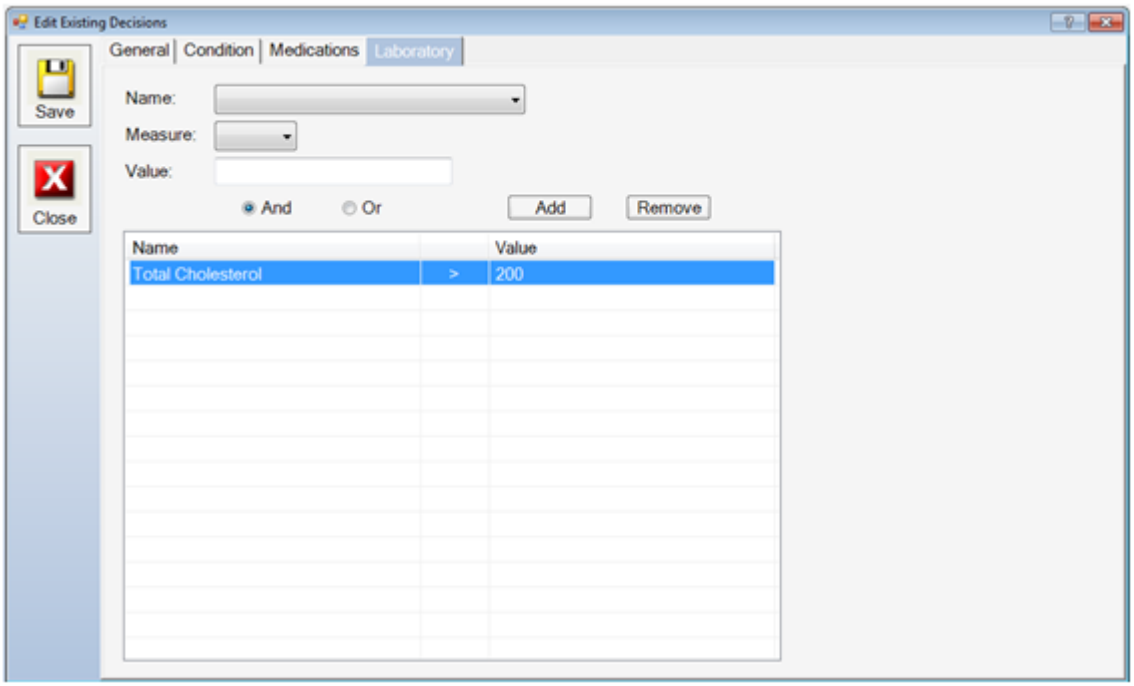
The second tab will allow you to select diagnosis codes that you want to associate with this particular decision rule.



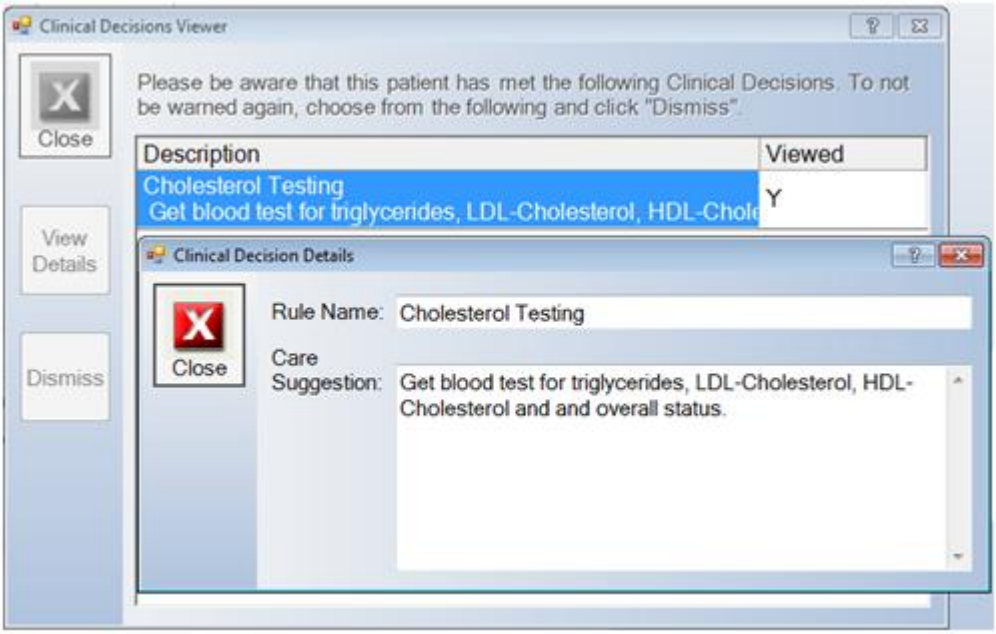
The third tab will allow you to select specific medications that you want to associate with this decision rule.



The fourth and final tab will allow you to select specific laboratory test results that you want to associate with this decision rule.



Once choices have been made and the decision rule has been created, ChiroWrite will be able to search for patients fitting the criteria selected and point the patient out. Should the patient meet the criteria at any time a pop up will appear so that the message for the rule that the patient has met can be viewed. We can see that this patient should be advised to get a cholesterol test.

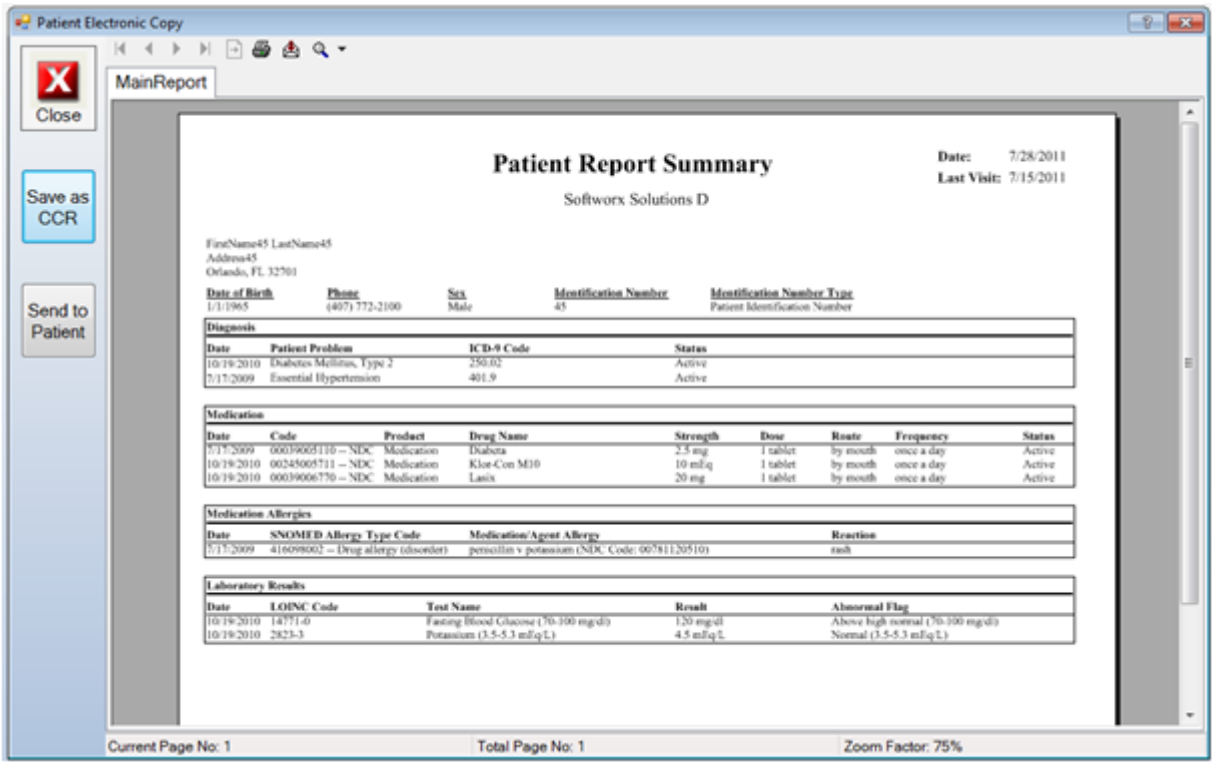

Clinical Decisions Viewer
Close
Please be aware that this patient has met the following Clinical Decisions. To not be warned again, choose from the following and click "Dismiss".
Description
Viewed
Cholesterol Testing
Get blood test for triglycerides, LDL-Cholesterol, HDL-Chole
Y
View Details
Dismiss
Clinical Decision Details
Close
Rule Name:
Cholesterol Testing
Care Suggestion:
Get blood test for triglycerides, LDL-Cholesterol, HDL-Cholesterol and and overall status.

Electronic Copy of Health Information

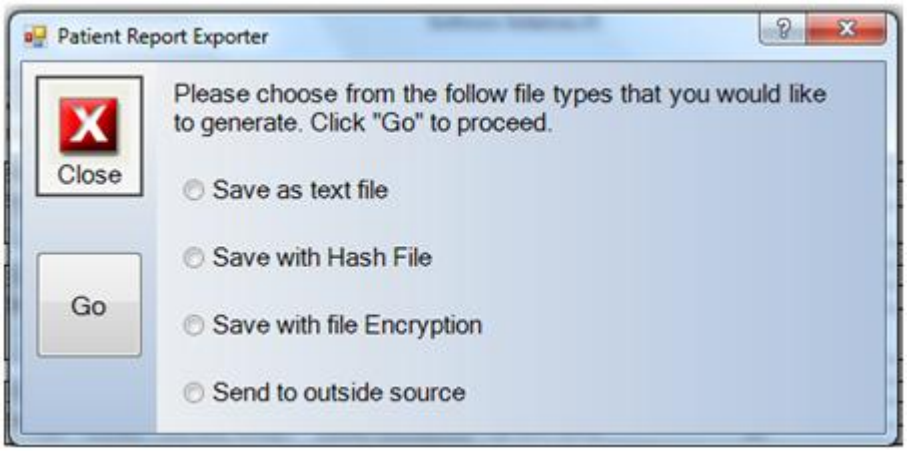
You must provide patients with an electronic copy of their health information upon request for more than 50 percent of all patients who request an electronic copy of their health information. This needs to be provided within 3 business days.

You can be excluded, if you do not have any requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period. Information in the electronic copy must consist of diagnostic test results, problem list, medication list, medication allergy list, etc.

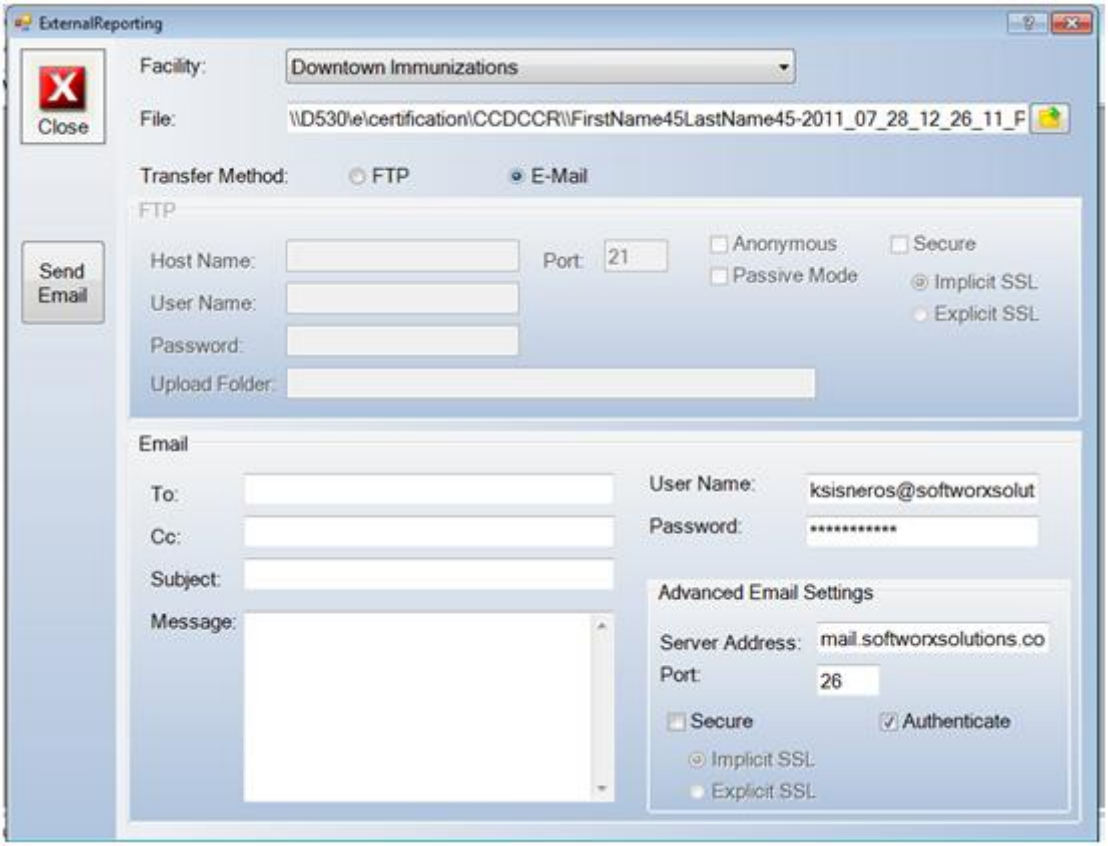
In ChiroWrite, you can access the electronic copy of health information by navigating to Patient Activities > Electronic Copy. This will run the patient's report shown below. Remember this information is for the present day visit or the most recent visit only. This can be printed out for patients or sent directly to the Microsoft HealthVault so that the patient has electronic access to the same information. It can also be saved as an XML file by clicking on the Save as CCR button to allow it to be sent to someone. Additional information can be found by watching the Electronic Copy of Health Information video.


Patient Electronic Copy
Close
Save as CCR
Send to Patient
MainReport
Patient Report Summary
Softworx Solutions D
Date: 7/28/2011
Last Visit: 7/15/2011
FirstName45 LastName45
Address45
Orlando, FL 32701
Date of Birth 1/1/1965
Phone (407) 772-2100
Sex Male
Identification Number 45
Identification Number Type Patient Identification Number
Diagnosis
Date Patient Problem ICD-9 Code Status
10/19/2010 Diabetes Mellitus, Type 2 250.02 Active
7/17/2009 Essential Hypertension 401.9 Active
Medication
Date Code Product Drug Name Strength Dose Route Frequency Status
7/17/2009 00039005110 -- NDC Medication Diabeta 2.5 mg 1 tablet by mouth once a day Active
10/19/2010 00245005711 -- NDC Medication Klor-Con M10 10 mEq 1 tablet by mouth once a day Active
10/19/2010 00039006770 -- NDC Medication Lasix 20 mg 1 tablet by mouth once a day Active
Medication Allergies
Date SNOMED Allergy Type Code Medication/Agent Allergy Reaction
7/17/2009 416098002 -- Drug allergy (disorder) penicillin v potassium (NDC Code: 00781120510) rash
Laboratory Results
Date LOINC Code Test Name Result Abnormal Flag
10/19/2010 14771-0 Fasting Blood Glucose (70-100 mg/dl) 120 mg/dl Above high normal (70-100 mg/dl)
10/19/2010 2823-3 Potassium (3.5-5.3 mEq/L) 4.5 mEq/L Normal (3.5-5.3 mEq/L)
Current Page No: 1
Total Page No: 1
Zoom Factor: 75%

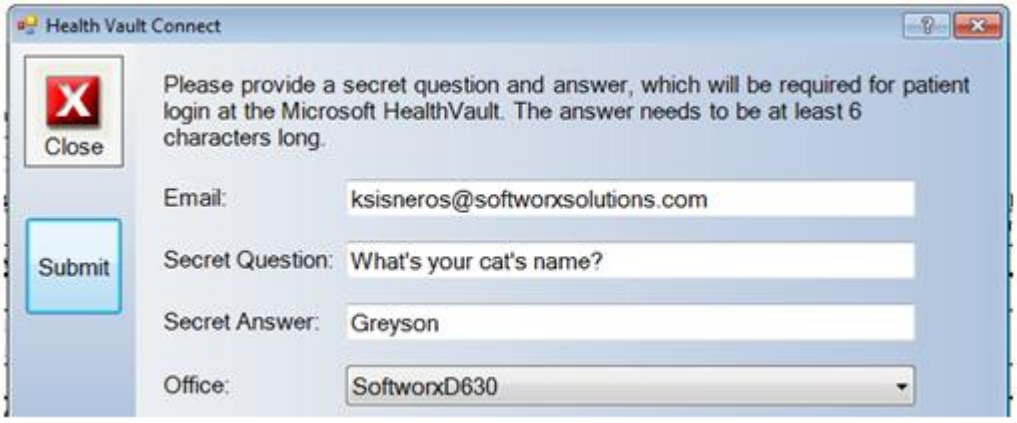
Clicking the print button will allow you to print the information for the patient. This is generally the easiest option. Clicking the Save As CCR button will allow you to save the file as text, with a hash code, save the file with encryption or send it directly to an outside source.


Patient Report Exporter
Close
Go
Please choose from the follow file types that you would like to generate. Click "Go" to proceed.
Save as text file
Save with Hash File
Save with file Encryption
Send to outside source

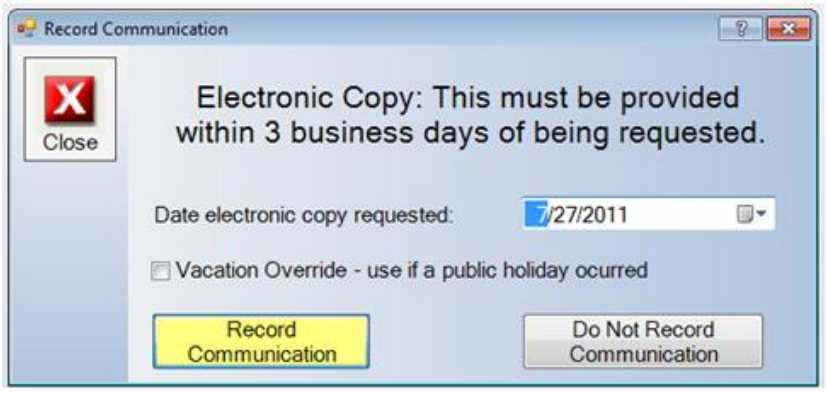
Sending to an outside source will allow you to securely FTP it somewhere or allow you to email it directly to someone. The individual you are sending the file to should have an application that can read XML documents otherwise the individual receiving the file will not be able to read the document.



If you click the Send to Patient button the system will require some secret questions to be answered by the patient so that when they receive the email to get into the Microsoft HealthVault they are the only one with the information. Once you click the Submit button, the system will let you know if it successfully submitted the information to the HealthVault.



Once you have taken the necessary steps to send the information to the patient, the system will ask if you would like to record the communication. By recording the communication, ChiroWrite will be able to calculate whether or not you have taken the necessary steps to meet the measure.

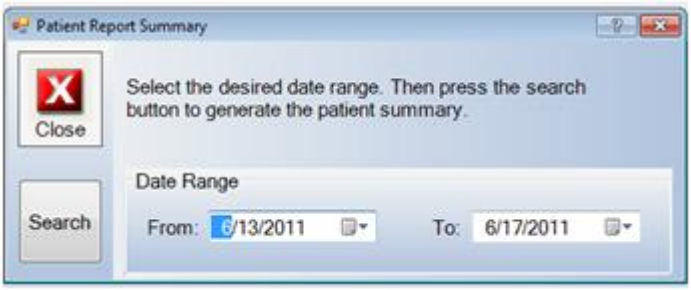

Record Communication
Close
Electronic Copy: This must be provided within 3 business days of being requested.
Date electronic copy requested:
7/27/2011
Vacation Override - use if a public holiday ocurred
Record Communication
Do Not Record Communication

Clinical Summaries

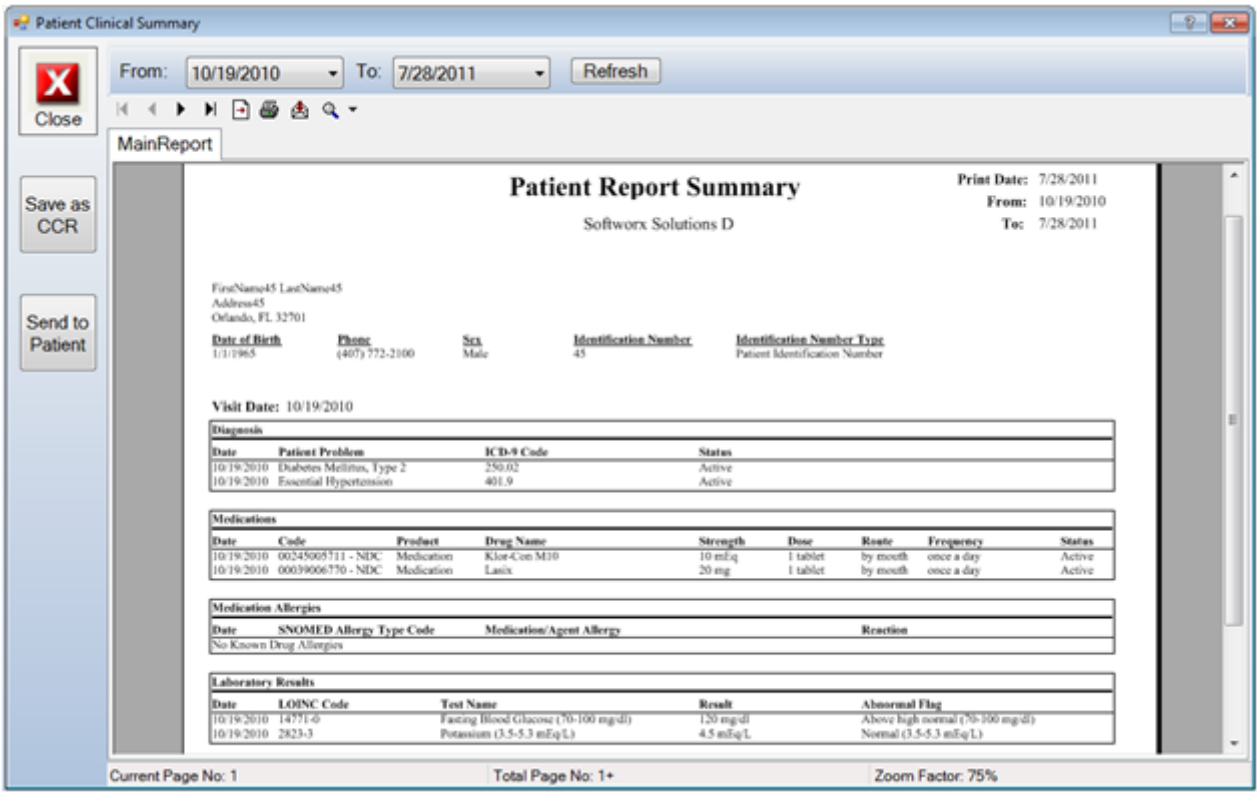
You must provide clinical summaries for patients for each office visit for more than 50 percent of all office visits within 3 business days.

You can be excluded from this if you do not have any office visits during the EHR reporting period.

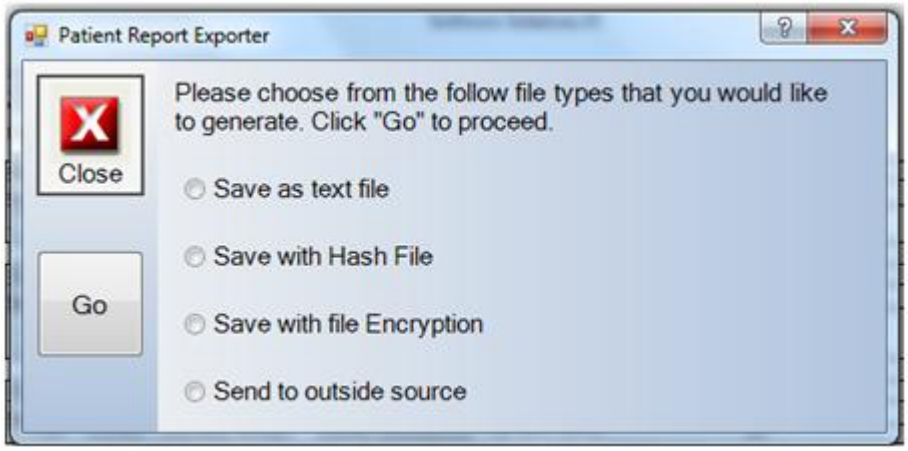
In ChiroWrite, you can access the clinical summaries by navigating to Patient Activities > Clinical Summaries. This will allow you to run the patient's report shown below. First, you select a date range for which you want the reports run and click the search button. Additional information can be viewed by watching the [Clinical Summaries] video.



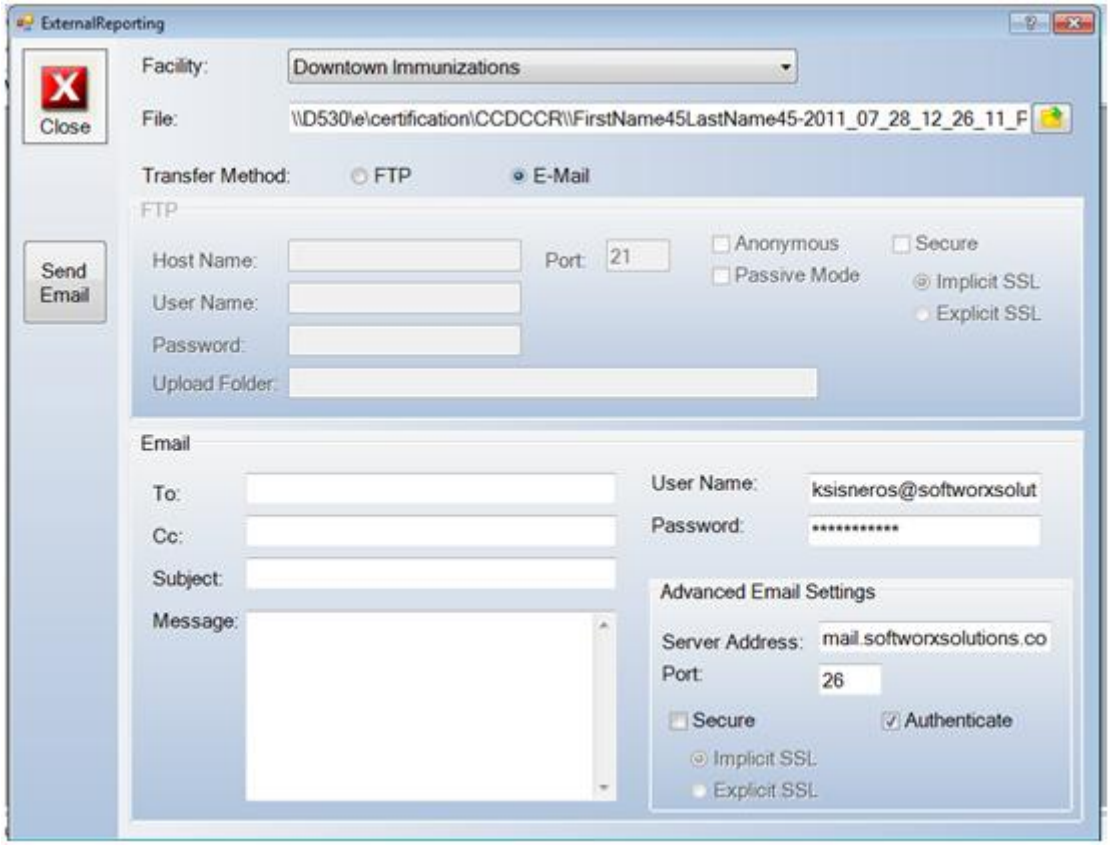
The reports can be printed out for patients or sent directly to the Microsoft HealthVault so that the patient has electronic access to the same information. It can also be saved as an XML file by clicking on the Save as CCR button to allow it to be sent to someone.


Patient Clinical Summary
Close
Save as CCR
Send to Patient
From: 10/19/2010
To: 7/28/2011
Refresh
MainReport
Patient Report Summary
Softworx Solutions D
Print Date: 7/28/2011
From: 10/19/2010
To: 7/28/2011
FirstName45 LastName45
Address45
Orlando, FL 32701
Date of Birth 1/1/1965
Phone (407) 772-2100
Sex Male
Identification Number 45
Identification Number Type Patient Identification Number
Visit Date: 10/19/2010
Diagnosis
Date Patient Problem ICD-9 Code Status
10/19/2010 Diabetes Mellitus, Type 2 250.02 Active
10/19/2010 Essential Hypertension 401.9 Active
Medications
Date Code Product Drug Name Strength Dose Route Frequency Status
10/19/2010 00245005711 - NDC Medication Klor-Con M10 10 mEq 1 tablet by mouth once a day Active
10/19/2010 00039006770 - NDC Medication Lasix 20 mg 1 tablet by mouth once a day Active
Medication Allergies
Date SNOMED Allergy Type Code Medication/Agent Allergy Reaction
No Known Drug Allergies
Laboratory Results
Date LOINC Code Test Name Result Abnormal Flag
10/19/2010 14771-0 Fasting Blood Glucose (70-100 mg/dl) 120 mg/dl Above high normal (70-100 mg/dl)
10/19/2010 2823-3 Potassium (3.5-5.3 mEq/L) 4.5 mEq/L Normal (3.5-5.3 mEq/L)
Current Page No: 1
Total Page No: 1+
Zoom Factor: 75%

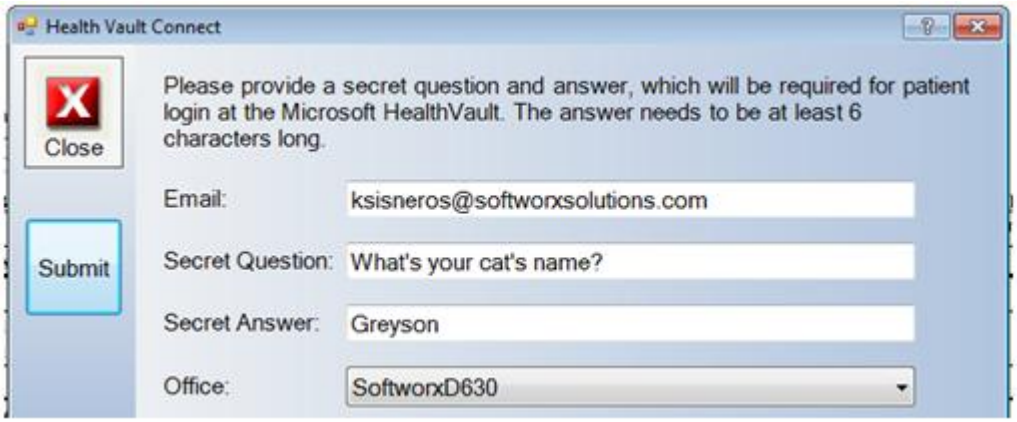
Clicking the print button will allow you to print the information for the patient. Clicking the Save As CCR button will allow you to save the file as text, with a hash code, save the file with encryption or send it directly to an outside source.


Patient Report Exporter
Close
Please choose from the follow file types that you would like to generate. Click "Go" to proceed.
Save as text file
Save with Hash File
Go
Save with file Encryption
Send to outside source

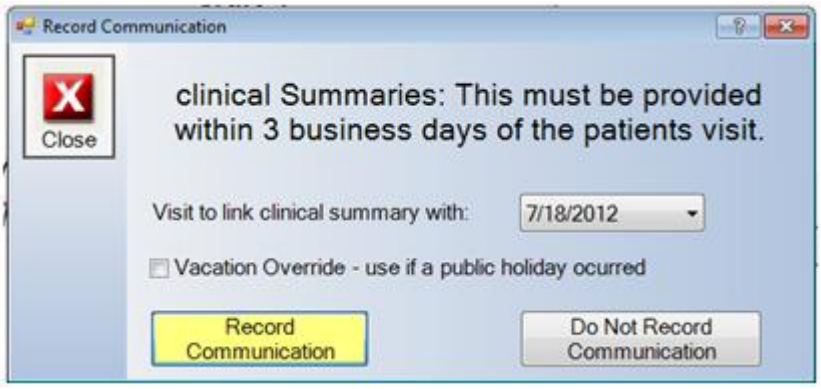
Sending to an outside source will allow you to securely FTP it somewhere or allow you to email it directly to someone. The individual you are sending the file to should have an application that can read XML documents otherwise the individual receiving the file will not be able to read the document.



If you click the Send to Patient button the system will require some secret questions to be answered by the patient so that when they receive the email to get into the Microsoft HealthVault they are the only one with the information. Once you click the Submit button, the system will let you know if it successfully submitted the information to the HealthVault.



Once you have taken the necessary steps to send the information to the patient, the system will ask if you would like to record the communication. By recording the communication, ChiroWrite will be able to calculate whether or not you have taken the necessary steps to meet the measure.


Record Communication
Close
clinical Summaries: This must be provided within 3 business days of the patients visit.
Visit to link clinical summary with:
7/18/2012
Vacation Override - use if a public holiday ocurred
Record Communication
Do Not Record Communication

Electronic Exchange of Clinical Information

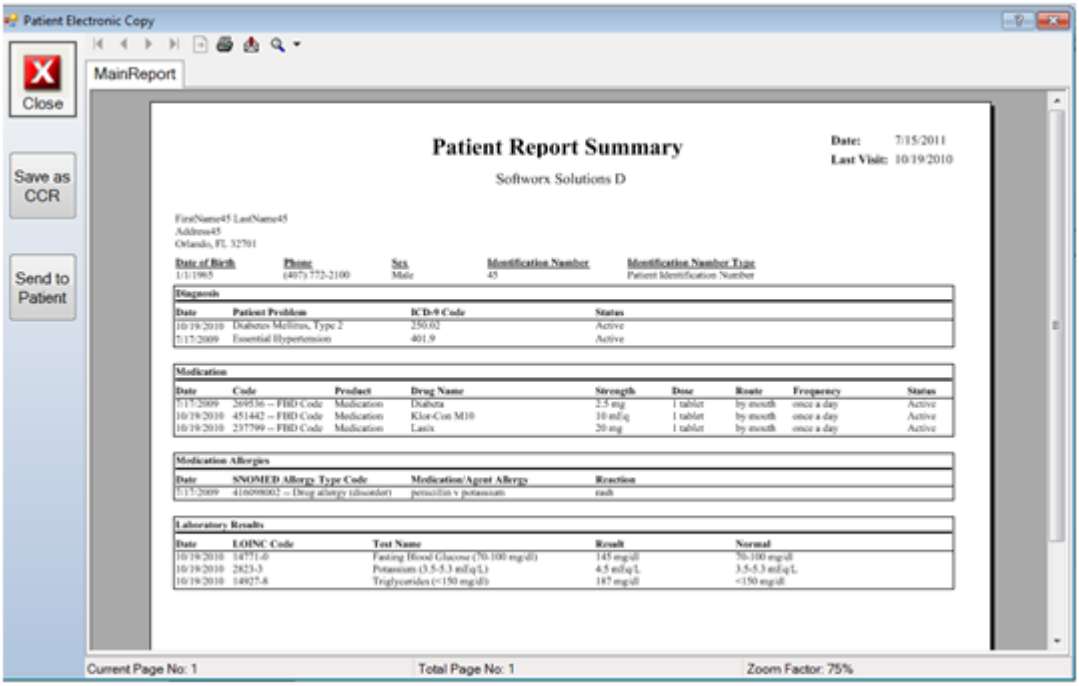
You must be able to exchange key clinical information among providers of care and patient authorized entities electronically.

There is no exclusion. You must attest yes for this requirement.

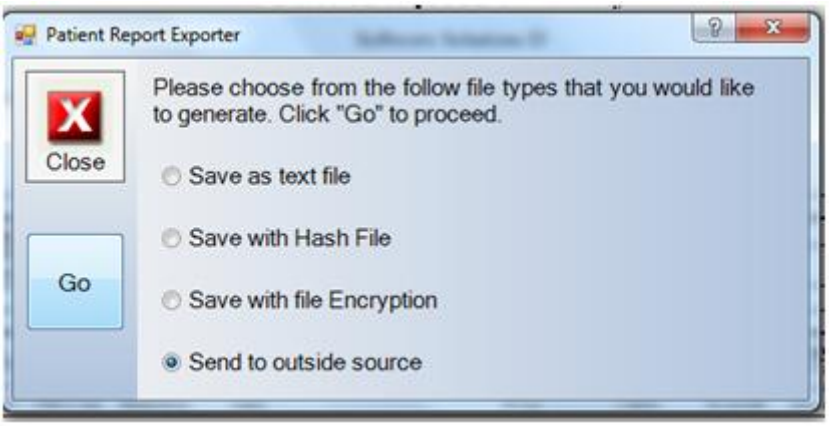
In ChiroWrite, you can complete the electronic exchange using email or you can send the file using secure ftp. Refer to the Meaningful Use Setup Guide to be sure your system is setup correctly. More information can be found by watching the Electronic Exchange of Health Information video.

Email

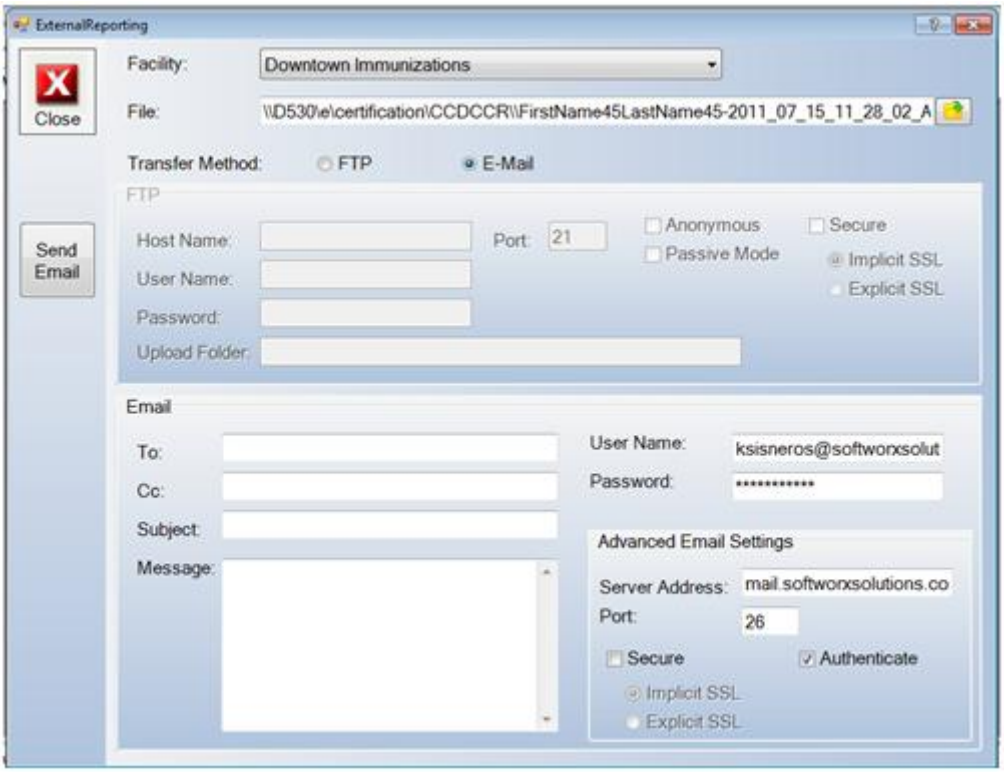
First, determine if you are sending a copy of one visit or multiple visits. A single visit should be sent using the electronic copy while multiple visits should be sent using the clinical summaries. Navigate to the electronic copy by going to Patient Activities > Electronic Copy and navigate to the clinical summaries by going to Patient Activities > Clinical Summaries. Either way once the report has been run, click the Save as CCR button.



Using the Patient Report Exporter, choose Send to outside source for email and ftp options. Click the Go button when you've made your selection.


Patient Report Exporter
Close
Go
Please choose from the follow file types that you would like to generate. Click "Go" to proceed.
Save as text file
Save with Hash File
Save with file Encryption
Send to outside source

If you have already setup the email settings then they will appear in the settings area. The rest of the email can be setup using the interface shown below. Click the Send Email button to send the email to the desired recipient.



FTP

First, determine if you are sending a copy of one visit or multiple visits. A single visit should be sent using the electronic copy while multiple visits should be sent using the clinical summaries. Navigate to the electronic copy by going to Patient Activities > Electronic Copy and navigate to the clinical summaries by going to Patient Activities > Clinical Summaries. Either way once the report has been run, click the Save as CCR button. Using the Patient Report Exporter, choose Send to outside source for email and ftp options. Click the Go button when you've made your selection. Make your selections for uploading to a desired FTP site and click the Upload File button when finished.

Note: Remember that sending the file is sending the XML file. The recipient of the file must have an application that can read XML so that the individual can read the file.

Protect Electronic Health Information

You must conduct or review a security risk analysis in accordance with the requirements and implement security updates as necessary while correcting any identified security deficiencies as part of the risk management process. This refers to the HIPAA Security Rule 45 CFR 164.308 (a)(1), which already requires you to conduct a security risk analysis and correct any identified security deficiencies as part of the risk management process.

You must attest yes for this requirement and there are no exclusions.

There are some additional considerations that you need to account for in your risk analysis. This includes both technical and physical considerations based on what HIPAA says, but we are only concerned about the technical considerations in ChiroWrite. Additional information can be found by watching the Protect Electronic Health Information video.

Technical Considerations

Backups - ChiroWrite is a database application that needs to be properly backed up and the back up removed from the server where it resides. The best option is to take the backup to another location. Whether this is done electronically or physically is up to the individual doctor. Please review the ChiroWrite User Manual for further information on how to back up properly or contact technical support at 800-642-6082 for further information.

Access Control - ChiroWrite allows you to create employee log in accounts and determine if the user is allowed to create new information within a patient's file or if they are just allowed to edit or just print reports. Check the meaningful use setup guide for more information about how to organize this.

Audit Control - ChiroWrite keeps track of who logs in when and the changes made by the user. Navigating to Administration > Audits > View Logon Audits will allow you to see who has logged in and when. Navigating to Office Activities > Audits while in a patient's file will allow you to see changes that have been made and by who.

Integrity Control - ChiroWrite has the ability to create files with Hash codes to later determine if the file has been altered or changed. ChiroWrite can read the Hash and the file to determine if it has been altered.

Transmission Security - ChiroWrite has the ability to encrypt an electronic copy of patient information that might be sent to another party. Copies of patient information can also be sent securely to an FTP site or emailed directly to another party. ChiroWrite can also send it to the Microsoft HealthVault for the patient to access later with a password and security question.

Emergency Access - ChiroWrite allows for a user to have emergency access in the event that an administrator cannot be reached to log in and get the information in the event of an urgent situation.

Auto Log-Off - ChiroWrite will terminate the current session you are working in after a specified amount of time.

Core Measures 101

The following videos were created to help ChiroWrite users understand the core measures and know what to do in ChiroWrite to complete them. The measures that doctors must complete have videos associated with them. The remaining measures the chiropractor would receive exclusions from as they do not deal with prescribing medications.

CPOE - Exclusion

Drug Interaction Checks

Problem List

E-Prescribing - Exclusion

Patient Medications Video

Medication Allergy Video

Record Demographics

Record Vital Signs

Record Smoking Status

Clinical Quality Measures

[Clinical Decision Support Rule]
[Electronic Copy of Health Information]
[Clinical Summaries]
[Electronic Exchange of Health Information]
[Protect Electronic Health Information]

Menu Measures

The menu measures are ones that the eligible professional is able to choose from. You must choose a total of 5 measures to complete from this menu set.

IMPORTANT: Eligible professionals must choose at least one objective out of the two public health measures (Immunization Registries Data Submission & Syndromic Surveillance Data Submission). The other 4 are completely optional.

Again, ChiroWrite does the calculations for you, but attestation online is the sole responsibility of the eligible professional.

Menu Measures

[Implement Drug Formulary Checks]
[Clinical Lab Test Results]
[Patient Lists]
[Patient Reminders]
[Timely Access]
[Patient Specific Education Resources]
[Medication Reconciliation]
[Transition of Care Summary]
[Immunization Registries Data Submission (1 of 2)]
[Syndromic Surveillance Data Submission (2 of 2)]

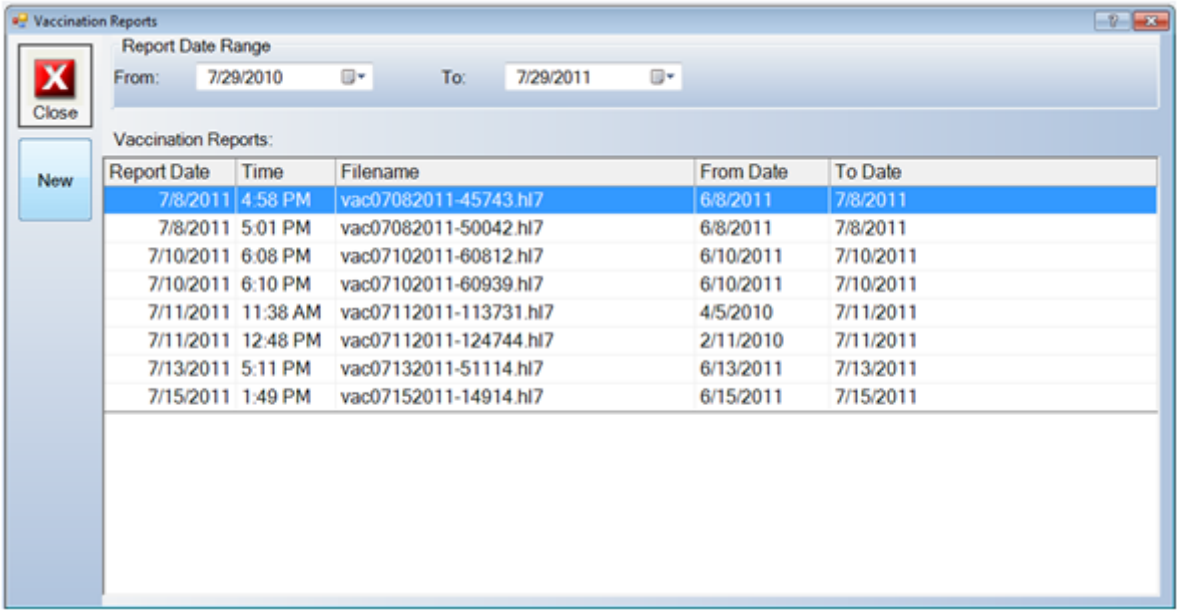
Immunization Registries Data Submission

You must submit electronic data to immunization registries or immunization information system and actual submission according to applicable law and practice, unless none of the immunization registries you submit to do not have the capacity to receive the information electronically.

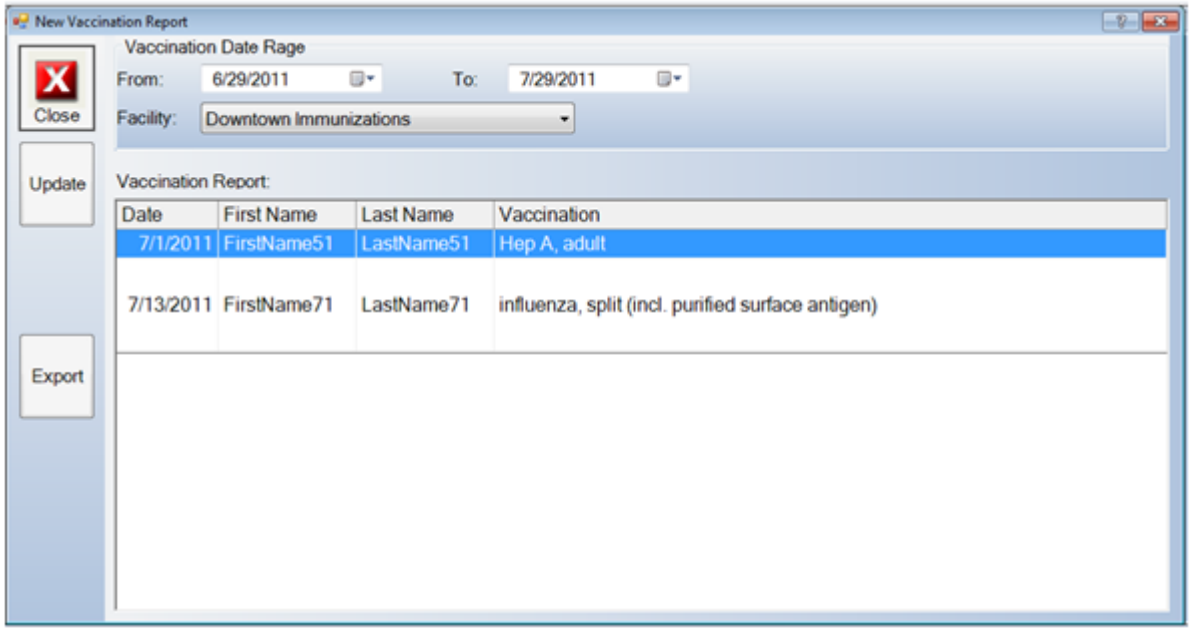
You can be excluded, if you administer no immunizations during the EHR reporting period or none of the immunization registries you submit to in your state have the capacity to receive the information electronically. You must attest yes or be excluded for this requirement.

IMPORTANT: Eligible professionals must choose at least one objective out of the two public health measures (Immunization Registries Data Submission & Syndromic Surveillance Data Submission).

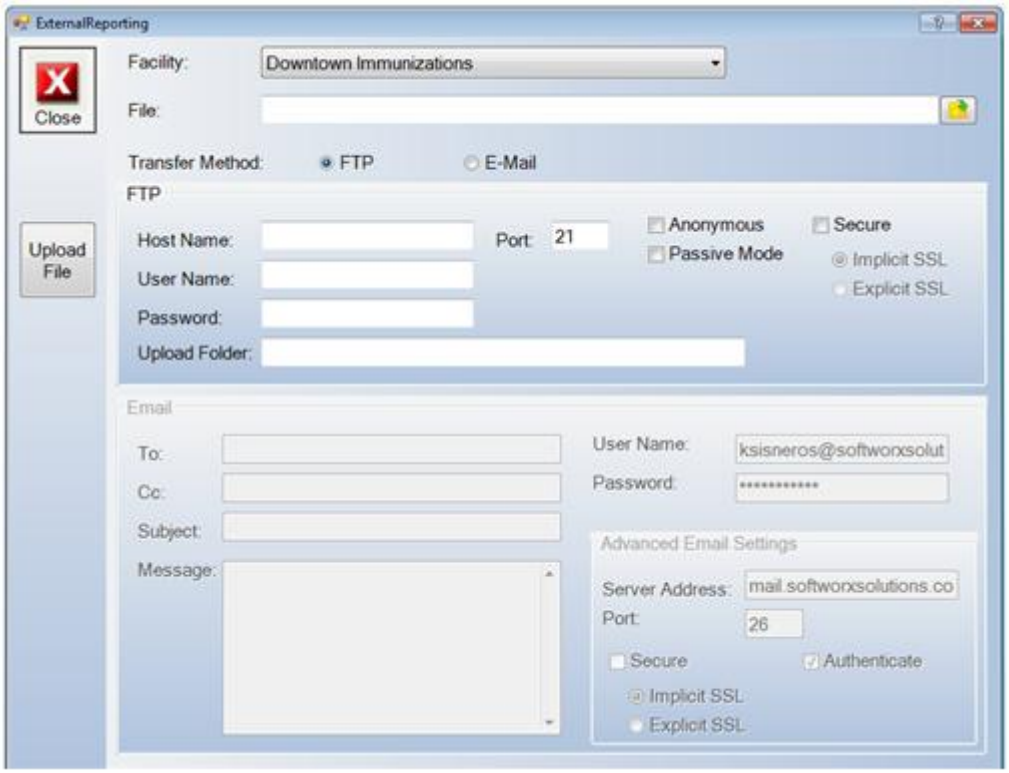
In ChiroWrite, generating the report can be completed by navigating to Office Activities > Vaccination Reporting. Click the New button to begin creating a new report for submission.



Select a date range to run the report for as well as the facility you might be sending the information to and then click the Update button. A list of all the vaccinations that have been given to the patient will be shown to you before the report is created. Click the Export button to generate the report.


New Vaccination Report
Close
Update
Export
Vaccination Date Rage
From: 6/29/2011
To: 7/29/2011
Facility: Downtown Immunizations
Vaccination Report:
Date | First Name | Last Name | Vaccination
7/1/2011 | FirstName51 | LastName51 | Hep A, adult
7/13/2011 | FirstName71 | LastName71 | influenza, split (incl. purified surface antigen)

Even though the file has been created, you still need to send it to the immunization registry. Click on Office Activities > Send File(s) to FTP the document or email it. The recipient will require an application to view HL7 files in order to read the file being sent. The immunization registry should have this capability if they are setup to receive electronic information.



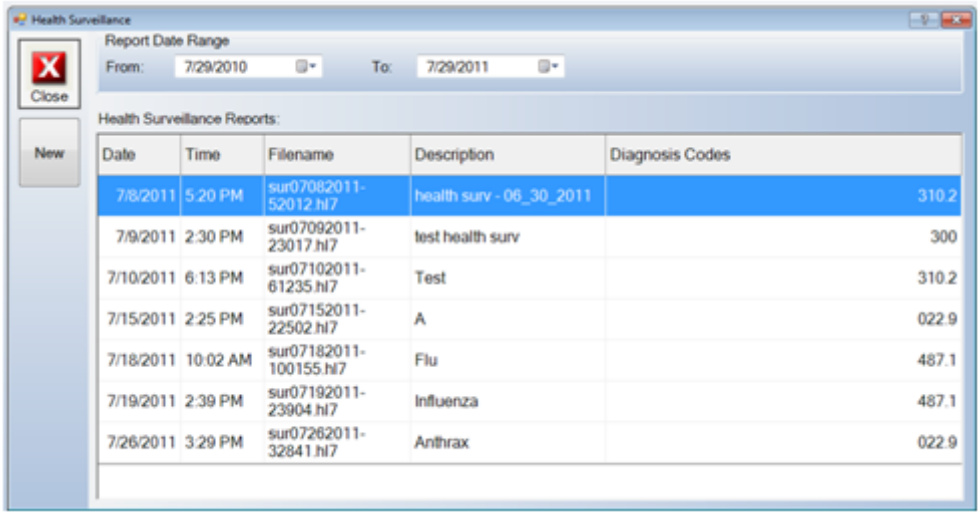
Syndromic Surveillance Data Submission

You must submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice, unless none of the public health agencies you submit to do not have the capacity to receive the information electronically.

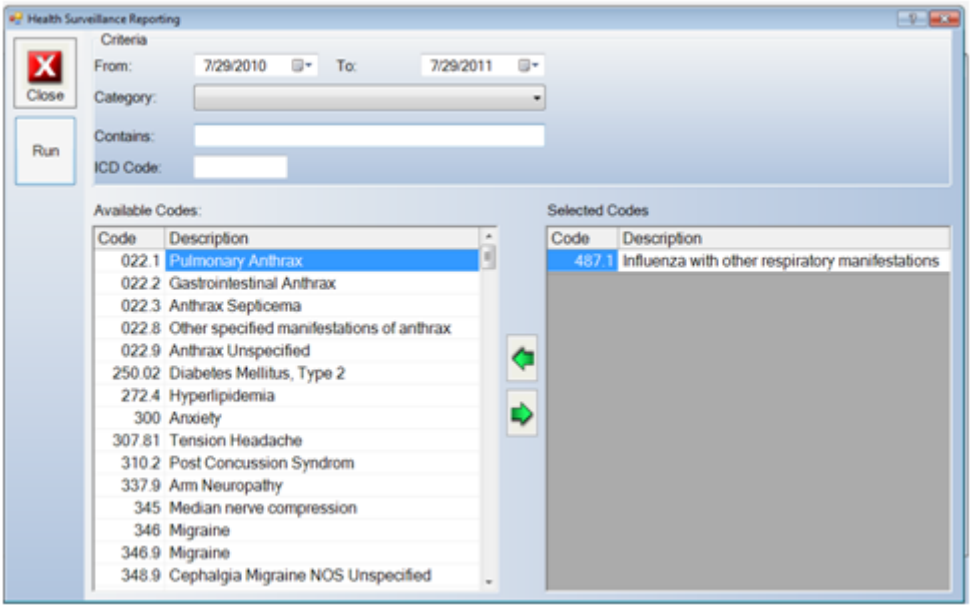
You can be excluded, if you do not collect any reportable syndromic information on patients during the EHR reporting period or none of the public health agencies you submit to do not have the capacity to receive the information electronically. You must attest yes or excluded for this requirement.

IMPORTANT: Eligible professionals must choose at least one objective out of the two public health measures (Immunization Registries Data Submission & Syndromic Surveillance Data Submission).

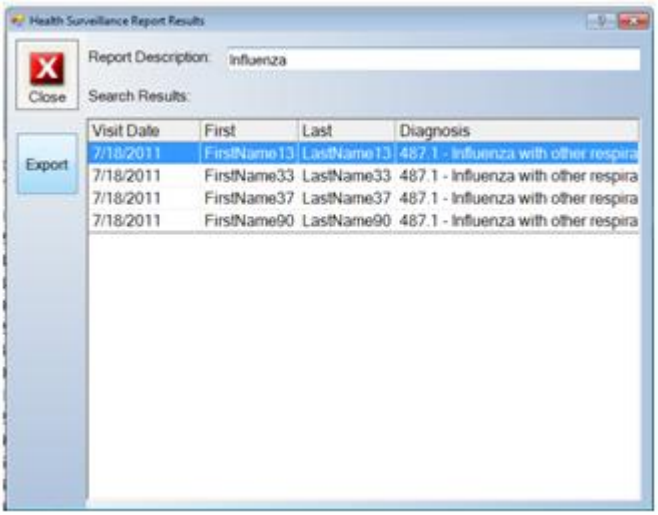
In ChiroWrite, generating the report can be completed by navigating to Office Activities > Health Surveillance. click on the New button to begin creating a new report for submission.



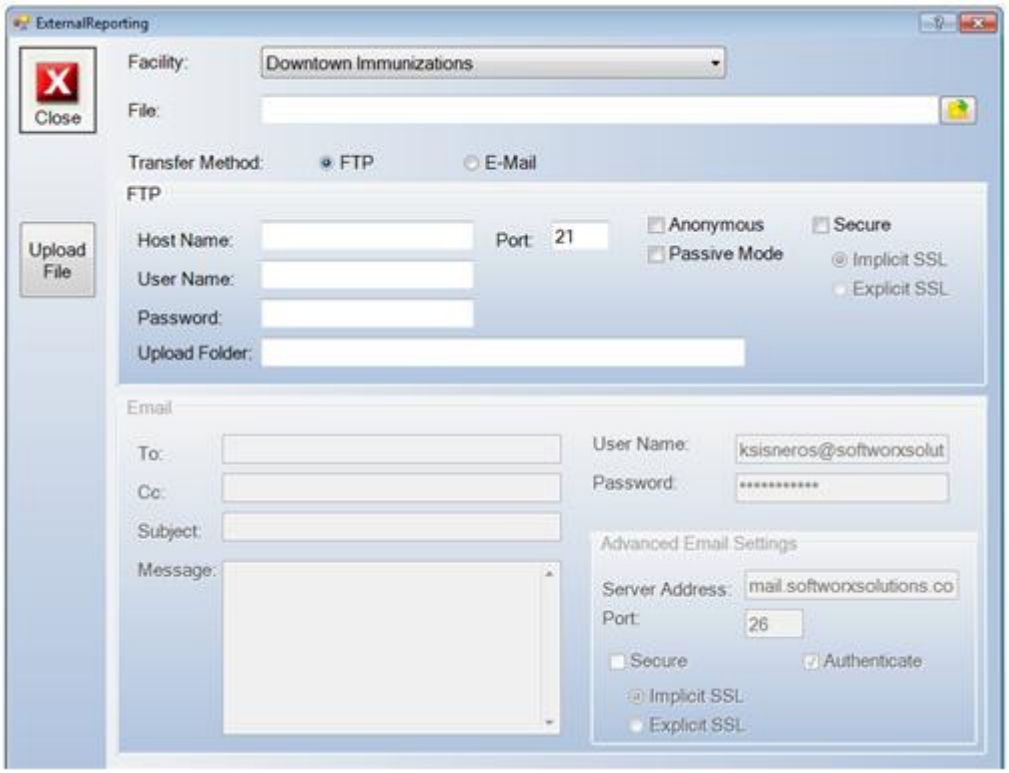
Select a date range to run the report for as well as the diagnosis or diagnoses you want to report on and then click the Run button.



A list of all the patients that have been diagnosed with the selection you made will be shown to you before the report is created. In the Report Description, name the report and then click the Export button to generate the report.


Health Surveillance Report Results
Close
Export
Report Description: Influenza
Search Results:
Visit Date First Last Diagnosis
7/18/2011 FirstName13 LastName13 487.1 - Influenza with other respira
7/18/2011 FirstName33 LastName33 487.1 - Influenza with other respira
7/18/2011 FirstName37 LastName37 487.1 - Influenza with other respira
7/18/2011 FirstName90 LastName90 487.1 - Influenza with other respira

Even though the file has been created, you still need to send it to the surveillance registry or the CMS. Click on Office Activities > Send File(s) to FTP the document or email it. The recipient will require an application to view HL7 files in order to read the file being sent. The surveillance registry or the CMS should have this capability if they are setup to receive electronic information.



Implement Drug Formulary Checks

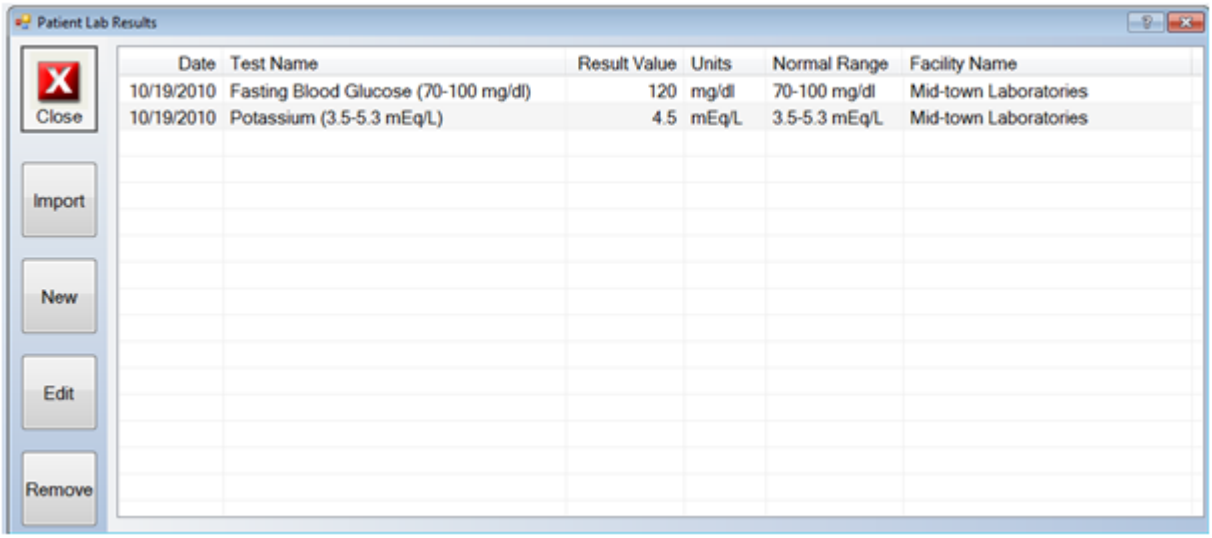
You must enable this functionality and have access to at least one internal or external formulary for the entire EHR reporting period. Rcopia takes care of this for you based on a patient's demographic information, they will pull the necessary formulary information.

You can be excluded if you write fewer than 100 prescriptions during the EHR reporting period. You must attest yes to this requirement.

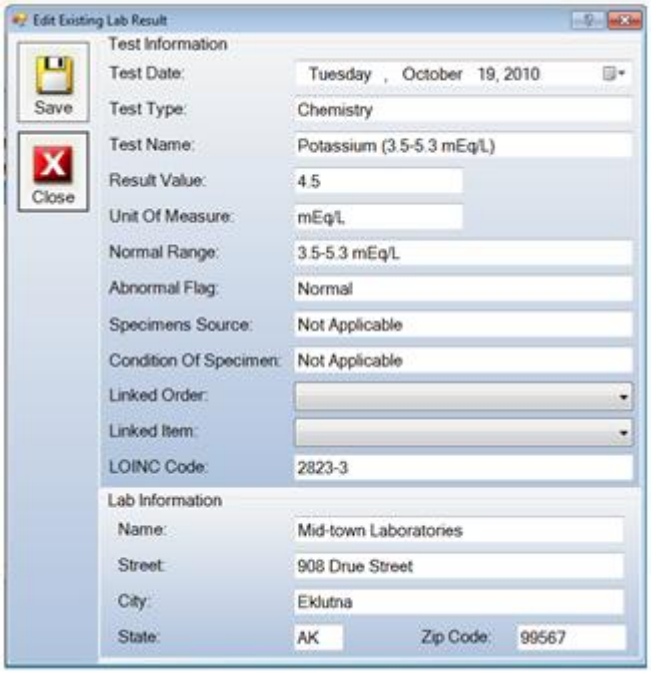
Clinical Lab Test Results

You must incorporate clinical lab test results for more than 40 percent of all clinical lab test results order during the EHR reporting period, where results are either positive or negative or in numerical format. So if you see 100 patients during the reporting period than at a minimum 41 of those patients should have their clinical lab test results entered into their file.

You can be excluded, if no lab tests were ordered whose results are either positive or negative or in numeric format. Laboratory tests include X-rays, MRI and other tests involving human fluids.

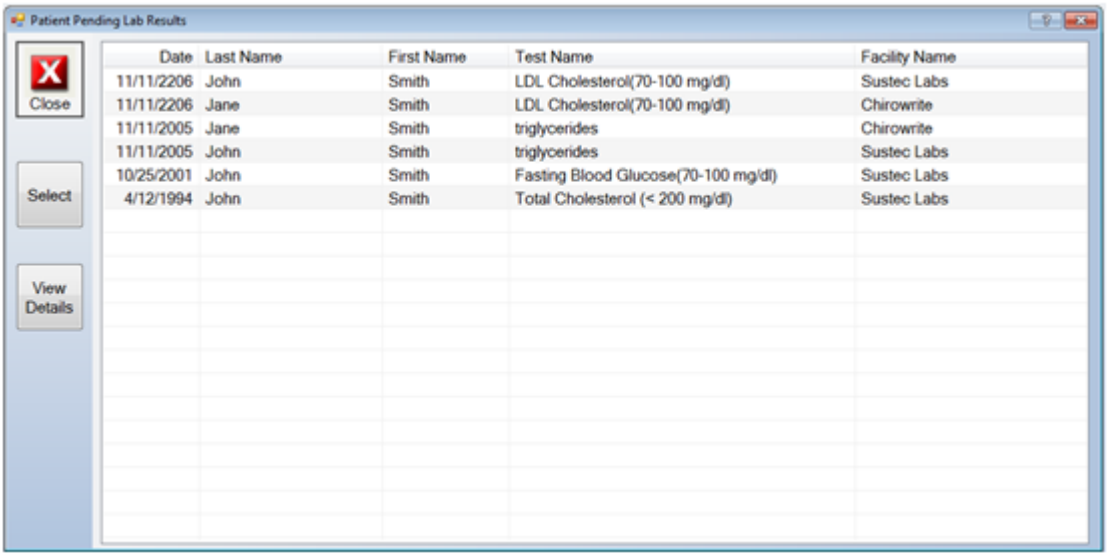


Entering in laboratory information is done by navigating to Patient Activities > Lab Results. Clicking the New button will allow you to enter in a new lab result and clicking the Edit button will allow you to change an existing lab result. The Remove button will allow you to delete an existing lab result from the file.



In order to gather any information that may have been acquired electronically from a lab, first navigate to File > Import > Lab Results. Once this has been completed, you will receive a message that the update has been complete. From this point, select a patient and navigate to Patient Activities > Lab Results.

Click the Import button to acquire the lab results that the system externally received and you will see a window like the one below. Now you are able to select a lab test and link it to a specific patient. You must already have selected the patient you want to work with for this to be successfully attached.

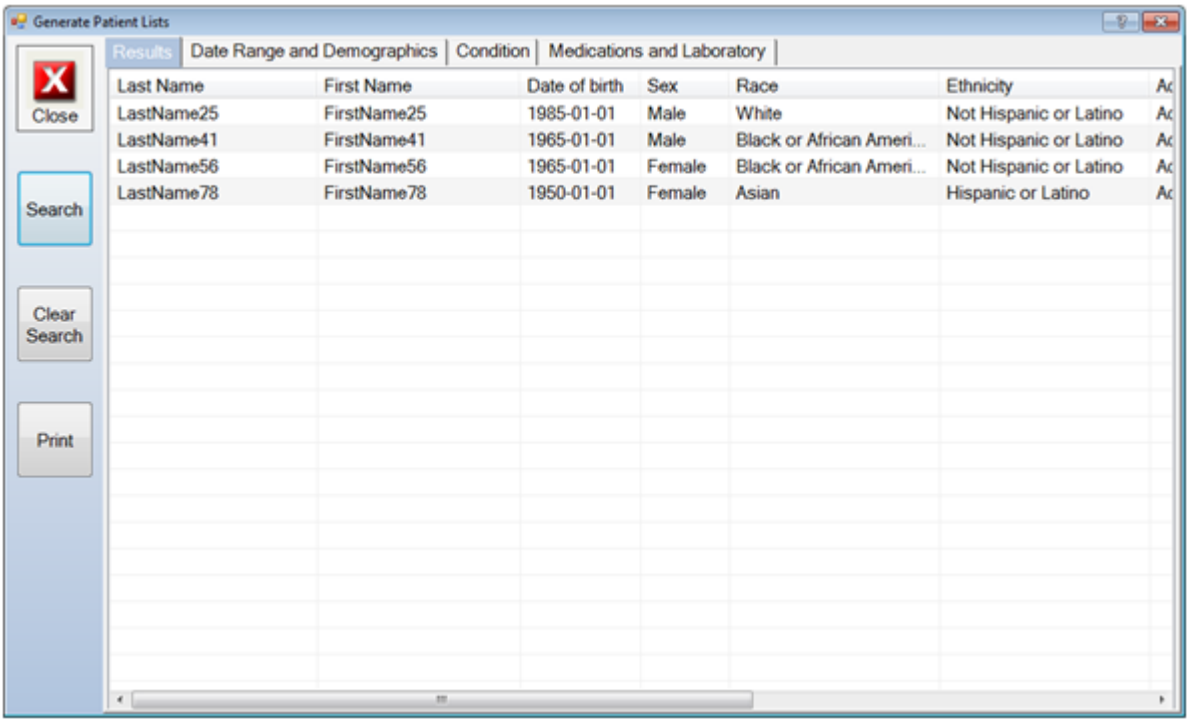

Patient Pending Lab Results
Close
Select
View Details
Date Last Name First Name Test Name Facility Name
11/11/2206 John Smith LDL Cholesterol(70-100 mg/dl) Sustec Labs
11/11/2206 Jane Smith LDL Cholesterol(70-100 mg/dl) Chirowrite
11/11/2005 Jane Smith triglycerides Chirowrite
11/11/2005 John Smith triglycerides Sustec Labs
10/25/2001 John Smith Fasting Blood Glucose(70-100 mg/dl) Sustec Labs
4/12/1994 John Smith Total Cholesterol (< 200 mg/dl) Sustec Labs

Patient Lists

You must be able to generate lists of patients by specific conditions to use for quality improvement, reduction or disparities, research or outreach.

There are no exclusions. You must attest yes to this requirement, if you determine you are using it to meet meaningful use.

In ChiroWrite, patient lists can be generated by navigating to Office Activities > Generate Patient Lists.


Generate Patient Lists
Close
Search
Clear Search
Print
Results
Date Range and Demographics
Condition
Medications and Laboratory
Last Name First Name Date of birth Sex Race Ethnicity
LastName25 FirstName25 1985-01-01 Male White Not Hispanic or Latino
LastName41 FirstName41 1965-01-01 Male Black or African Ameri... Not Hispanic or Latino
LastName56 FirstName56 1965-01-01 Female Black or African Ameri... Not Hispanic or Latino
LastName78 FirstName78 1950-01-01 Female Asian Hispanic or Latino

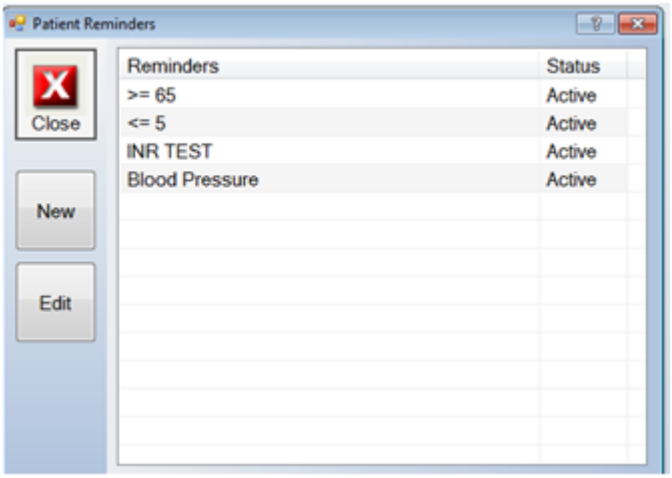
Once on this screen, you can proceed through the different tabs to search upon different criteria that will bring up the patients that fit that particular criteria. If the system cannot find any patients that match the criteria you are searching for the system will let you know that no patient's fit that criteria. You can sort the list by selecting the column header and the Print button will allow you to print the list in order to contact individual patients. For more information please watch the Patient Lists video.

Patient Reminders

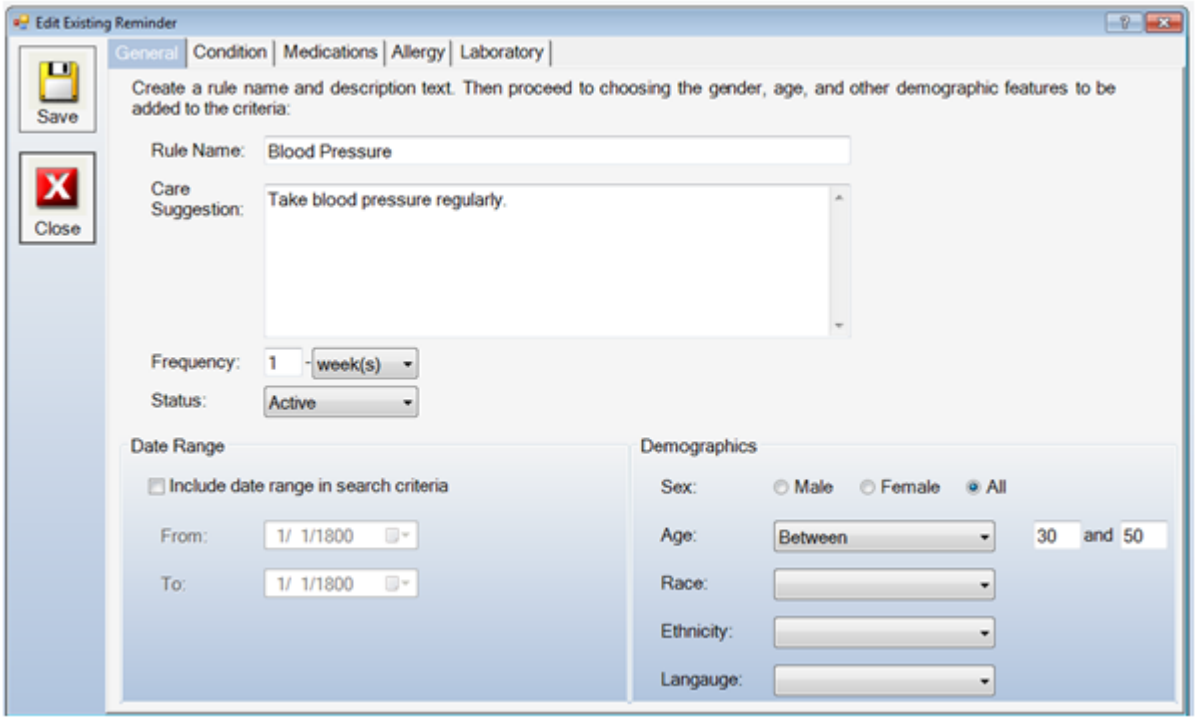
You must send appropriate reminders to patients per patient preference for preventative or follow up care for more than 20 percent of all patients 65 years or older or 5 years old or younger. So if you see 100 patients during the reporting period that are 65 years or older or 5 years old or younger than at a minimum 21 of those patients should have a reminder or some sort completed.

You can be excluded, if you see no patients 65 years or older or 5 years or younger. You must attest yes to this requirement, if used to meet meaningful use requirements.

In ChiroWrite, patient reminders can be setup by first navigating to Administration > Reminders.

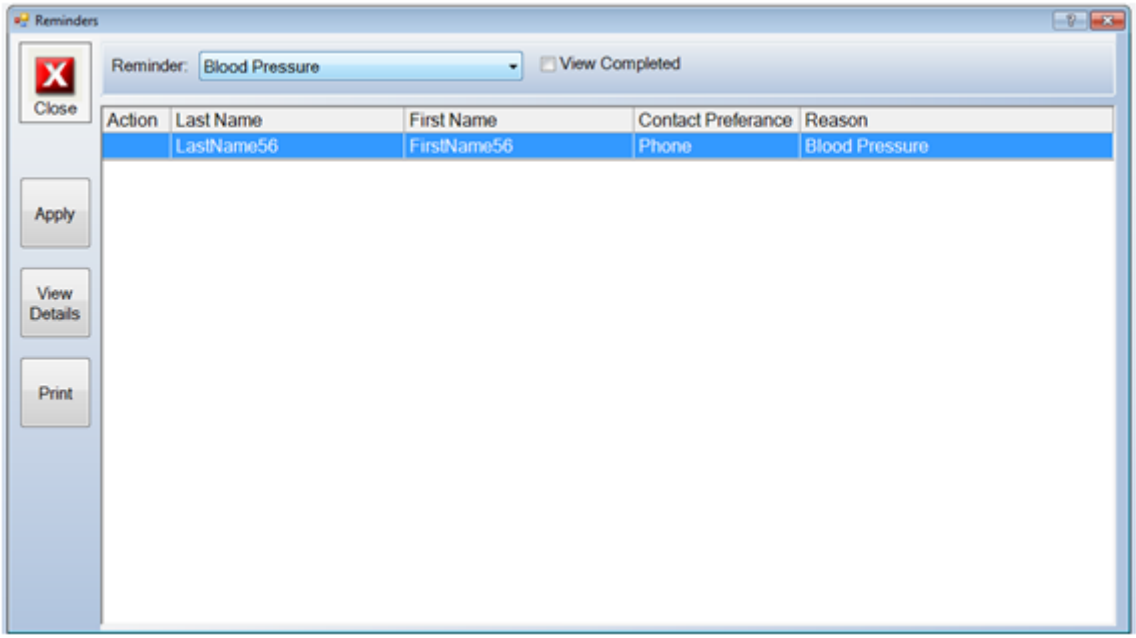


Once here, click the New button to begin creating a reminder and click the Edit button to make changes to an existing reminder.



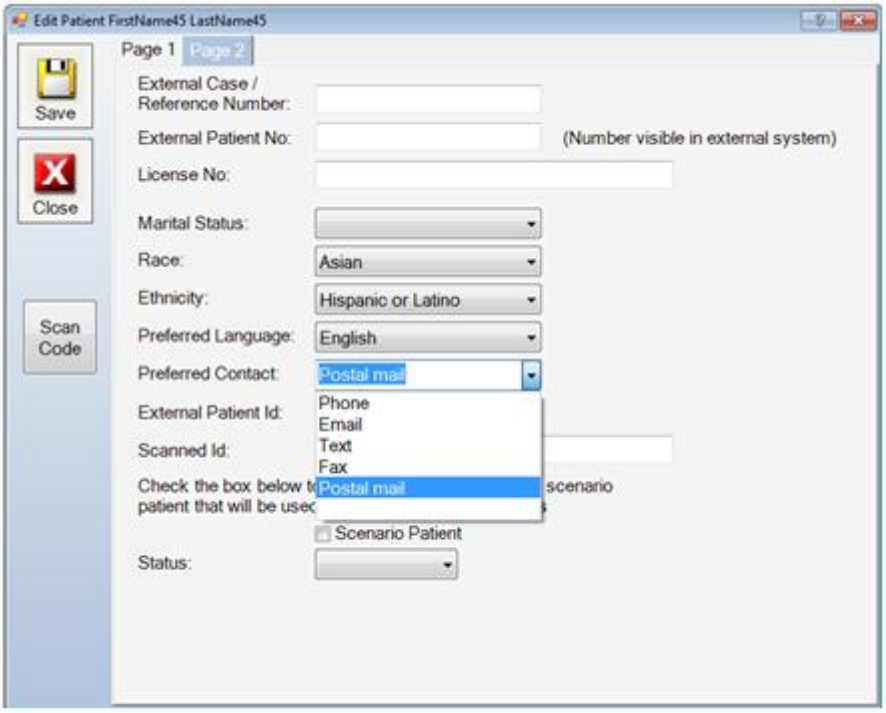
When creating a new reminder, select options from the tabs to select items you are looking for. Click Save

and close when complete. To view patients that fit the reminders you have created, navigate to Office Activities > Patient Reminders.



Select the reminder you wish to view from the drop down list and you will be shown the patients that fall under that reminder. Check the View Completed check box to view reminders that have been completed for specific date ranges. The action column will allow you to acknowledge that this reminder has been completed or ignore. Click apply after the selections have been made to apply changes. View Details will allow you to see patient information for the selected patient. Print will print the list of patients so that they can be contacted later. For additional information please watch the [Patient Reminders] video.

Contact Preference for a patient can be found under the patient demographics section. If you click on the contact card without the green plus, ***you will be able to edit this information on page 2.***

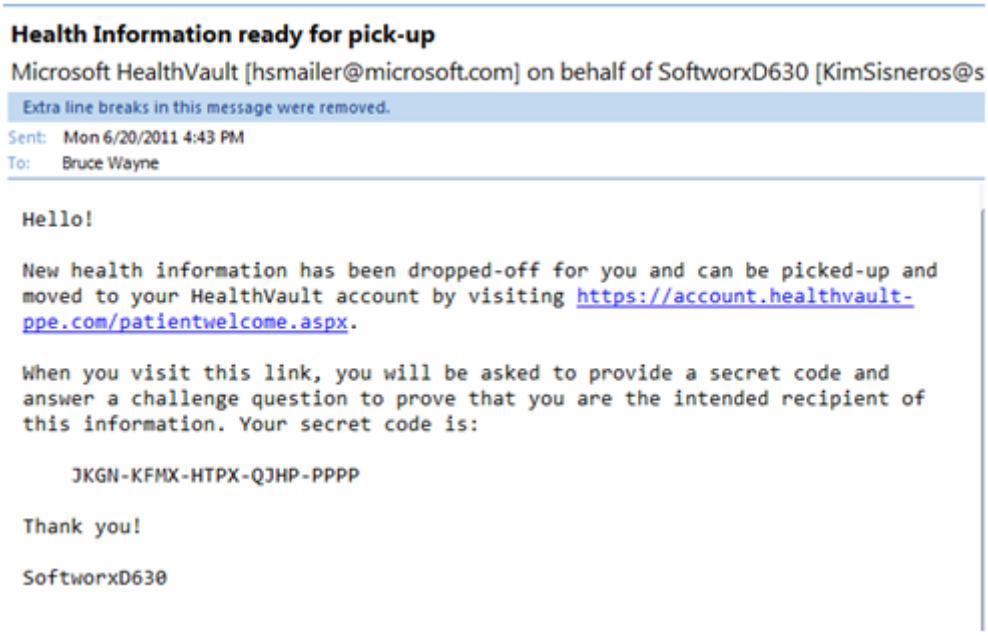


Patient Electronic Timely Access

You must provide patients with timely electronic access to their health information within 4 business days of the information being available to you. This must be done for at least 10 percent of all unique patients seen. So if you see 100 patients during the reporting period than at a minimum 11 of those patients should have their information sent to the Microsoft HealthVault within 4 business days so they have access to the information.

You can be excluded, if you neither order nor create lab tests or information that would be contained in the problem list, medication list, medication allergy list, ETC.

In ChiroWrite, we accomplish this by sending the patient information to Microsoft's HealthVault. Patients can access the HealthVault using a regular internet connection. They will receive an email with logon information that will allow them access to their records at any given time. Similar to the one shown below. For more information you can watch the Timely Access video.



Health Information ready for pick-up

Microsoft HealthVault [hsmailer@microsoft.com] on behalf of SoftworxD630 [KimSisneros@s

Extra line breaks in this message were removed.

Sent: Mon 6/20/2011 4:43 PM
To: Bruce Wayne

Hello!

New health information has been dropped-off for you and can be picked-up and moved to your HealthVault account by visiting https://account.healthvault-ppe.com/patientwelcome.aspx.

When you visit this link, you will be asked to provide a secret code and answer a challenge question to prove that you are the intended recipient of this information. Your secret code is:

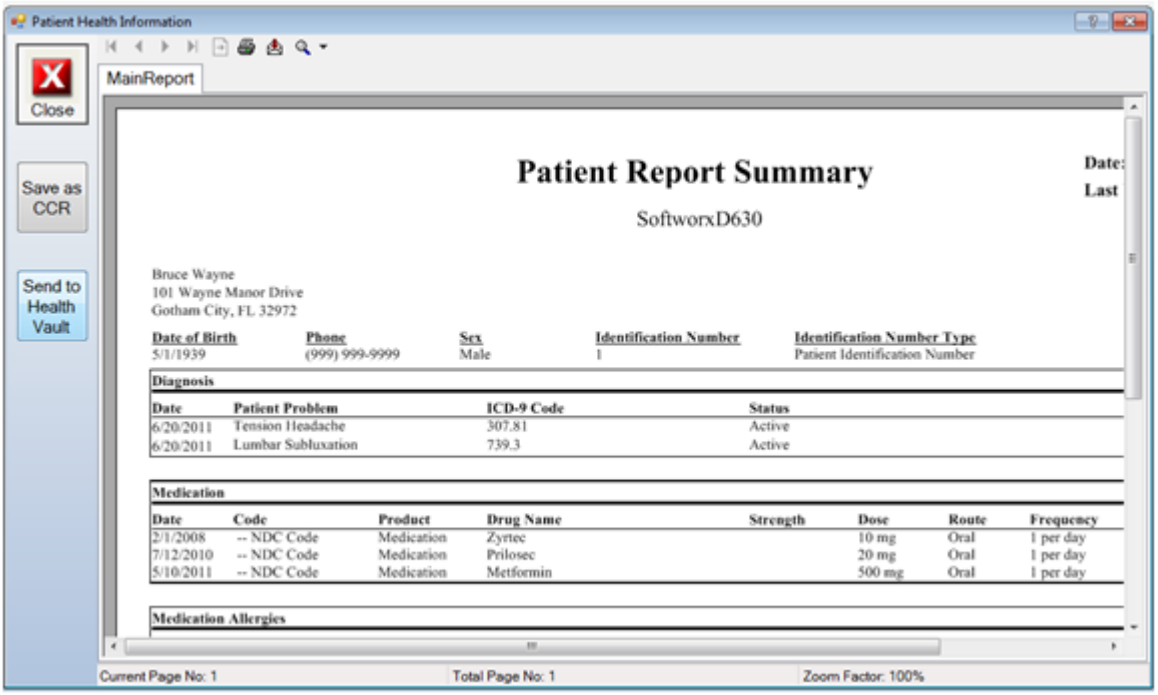
JKGN-KFMX-HTPX-QJHP-PPPP

Thank you!

SoftworxD630

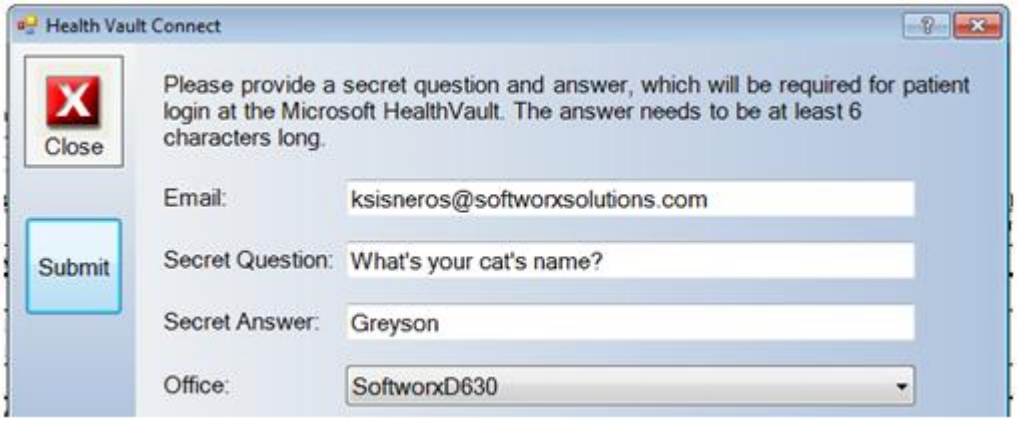
The patient can select the link and get into their information that you sent to the HealthVault.

You send information to the HealthVault by selecting a patient and navigating to Patient Activities > Electronic Copy.



Select the Send to HealthVault button and fill in the following sections with information known by the patient and select your office from the drop down you will be asked if you want to save this information to speed this process up at a later time. Click the submit button when finished. The system will ask you if you want to send the information to the HealthVault as which point you can say yes and the information will be sent to the HealthVault where your patient can later access it. You will get a message saying that the information was successfully sent to the HealthVault. Then you can click the close button to continue working in ChiroWrite.

Note: The Secret Answer must be at least 6 characters long.



Once you have taken the necessary steps to send the information to the patient, the system will ask if you would like to record the communication. By recording the communication, ChiroWrite will be able to calculate whether or not you have taken the necessary steps to meet the measure.

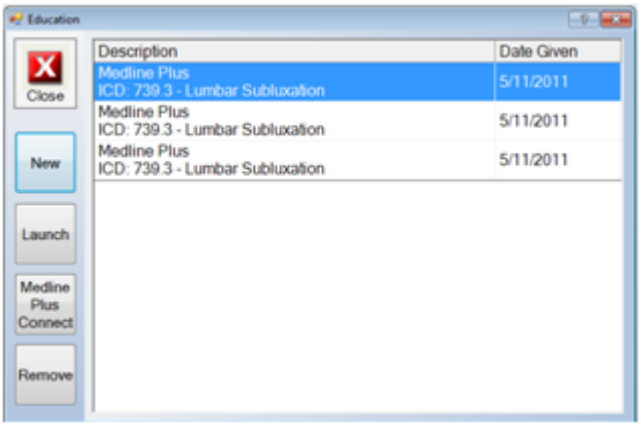
Record Communication
Close
Timely Access: This must be provided within 4 business days of information being available.
Information available on:
7/19/2012
Vacation Override - use if a public holiday ocurred
Record Communication
Do Not Record Communication

Patient Specific Education Resources

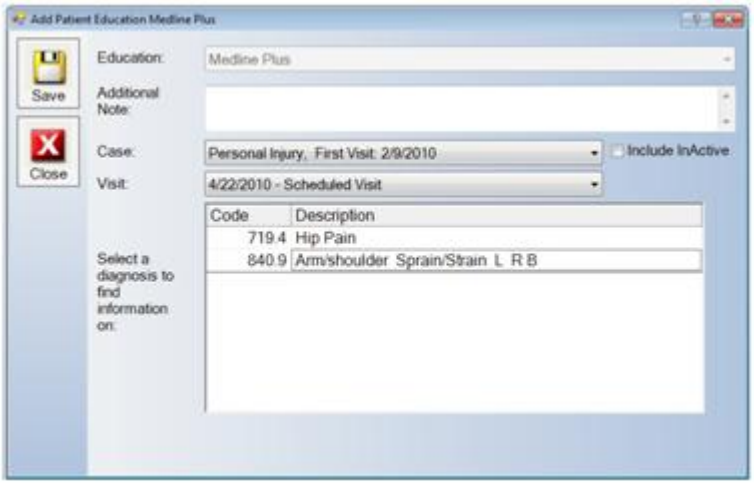
You must use ChiroWrite to identify patient specific education resources and provide those resources to the patient, if appropriate, for more than 10 percent of all unique patients seen. So if you see 100 patients during the reporting period than at a minimum 11 of those patients should be given specific education resources that fit their conditions, medications or anything that may be of value to the patient.

There is no exclusion for this measure.

In ChiroWrite, education resources can be brought up by selecting a patient and navigating to Patient Activities > Education.



Now, depending on how you have setup your system you may choose to click the new button if you already have resources you already like to give to patients. If this is the case, you will have static (resource is housed on a computer in your office) or dynamic (web based) resources for medications and laboratory results as well. Otherwise, most doctors are going to choose the Medline Plus Connect button and choose a diagnosis for which they would like information for.



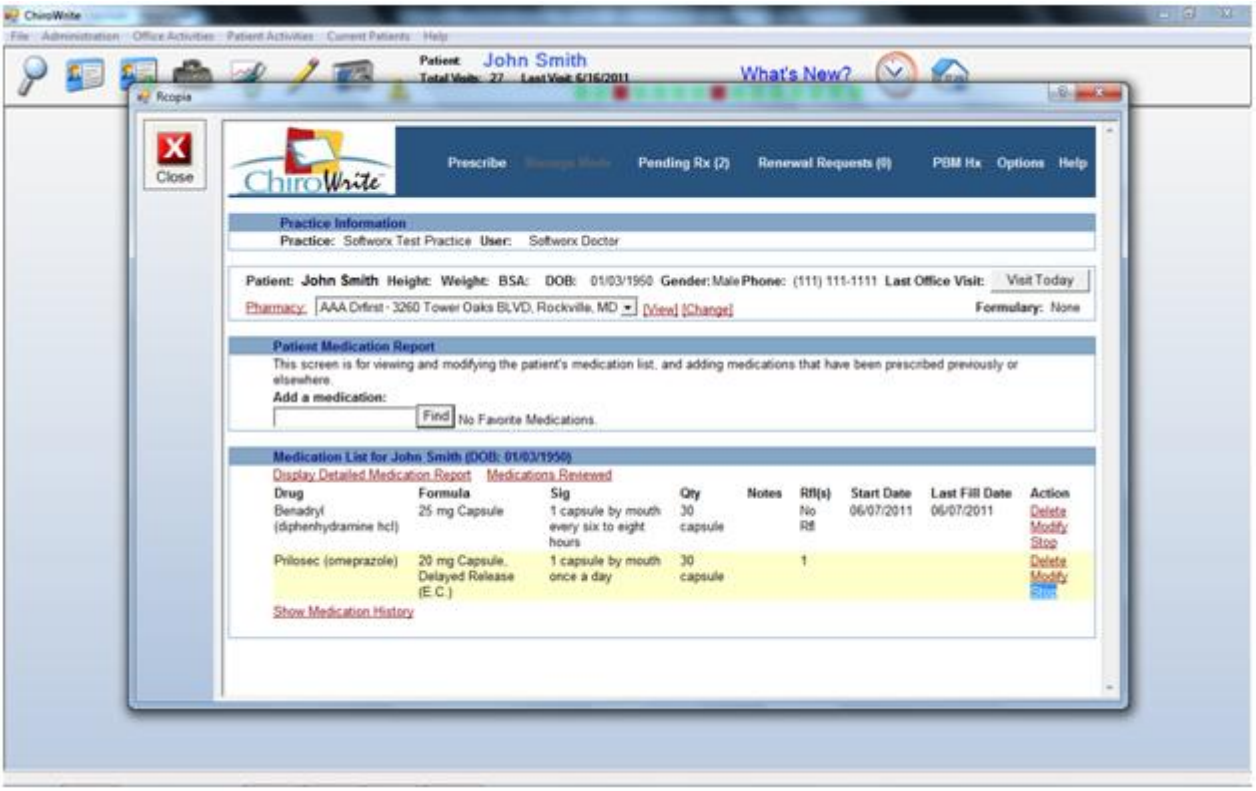
Clicking the save button after selecting a diagnosis will pop up an internet browser to Medline with information regarding that diagnosis. This can then be printed and given to the patient. For additional information please watch the [Patient Specific Education] video.

Medication Reconciliation

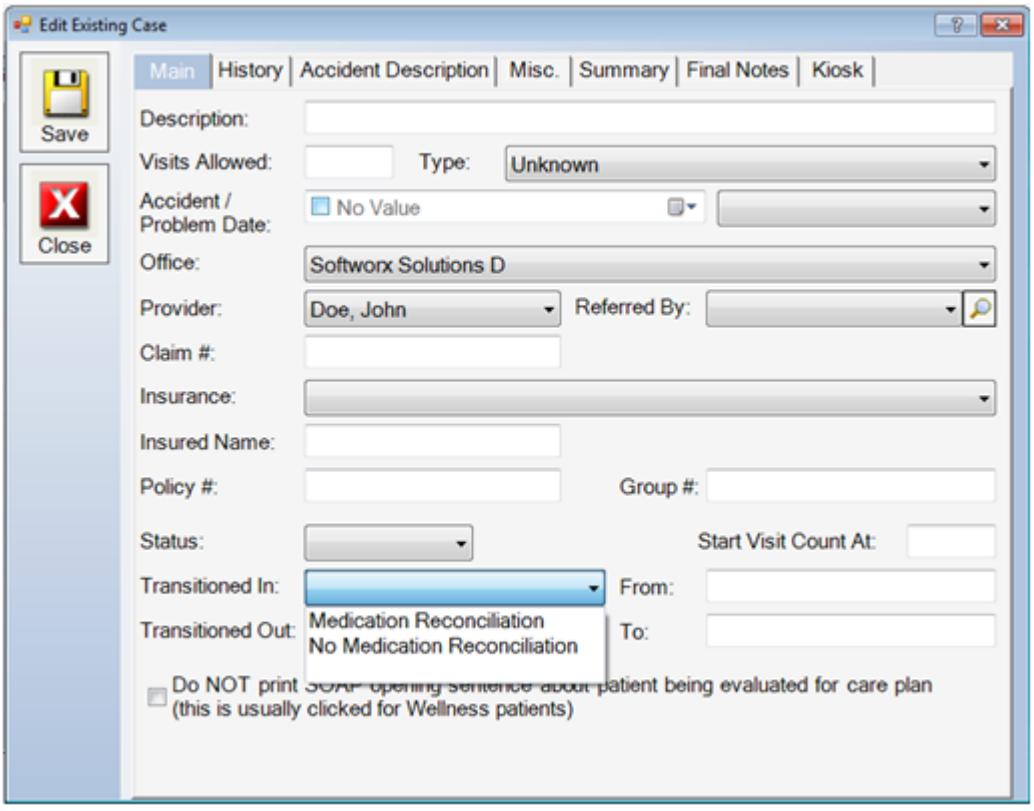
You must perform medication reconciliation for a patient that you receive from another setting or care or provider for more than 50 percent of transitions of care in which the patient is transitioned into your care. So if you see 100 patients that were transferred to you during the reporting period than at a minimum 51 of those patients should have medication reconciliation completed.

You can be excluded, if you are not the recipient of any transitions of care during the EHR reporting period. If you receive referrals from other doctors then you cannot be excluded if you are using this measure to meet meaningful use.

In ChiroWrite, you must first select a patient and then navigate to Patient Activities > Patient Medications and click the Manage button to launch Rcopia to begin adding and editing a patient's medication list. Ask the patient what they are currently taking and what they are no longer taking. If they are taking a new medication enter it into Rcopia. If they are an established patient and are no longer taking a medication then select the option to stop the medication. Stopping the medication rather than deleting it will allow you to keep a record of the patient having taken the medication; this is what is key to this meaningful use item. For additional information, please watch the [Medication Reconciliation] video.



If you have completed medication reconciliation for a patient that was referred to you then you must also navigate to the case information and select medication reconciliation from the Transitioned In drop down list. You can navigate to the case information either by selecting the doctor's bag ***and editing the case or selecting the yellow filing cabinet*** ***while in a note. The From section allows you to enter in the name of the doctor that referred the patient to you.***

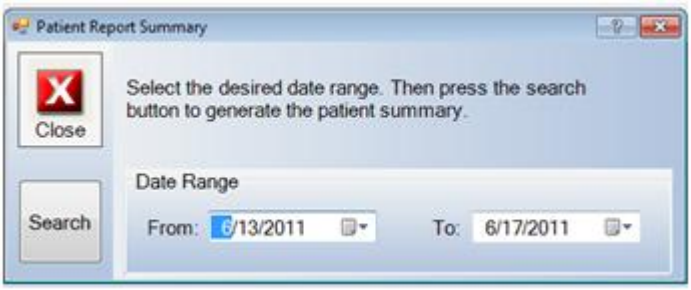


Transition of Care Summary

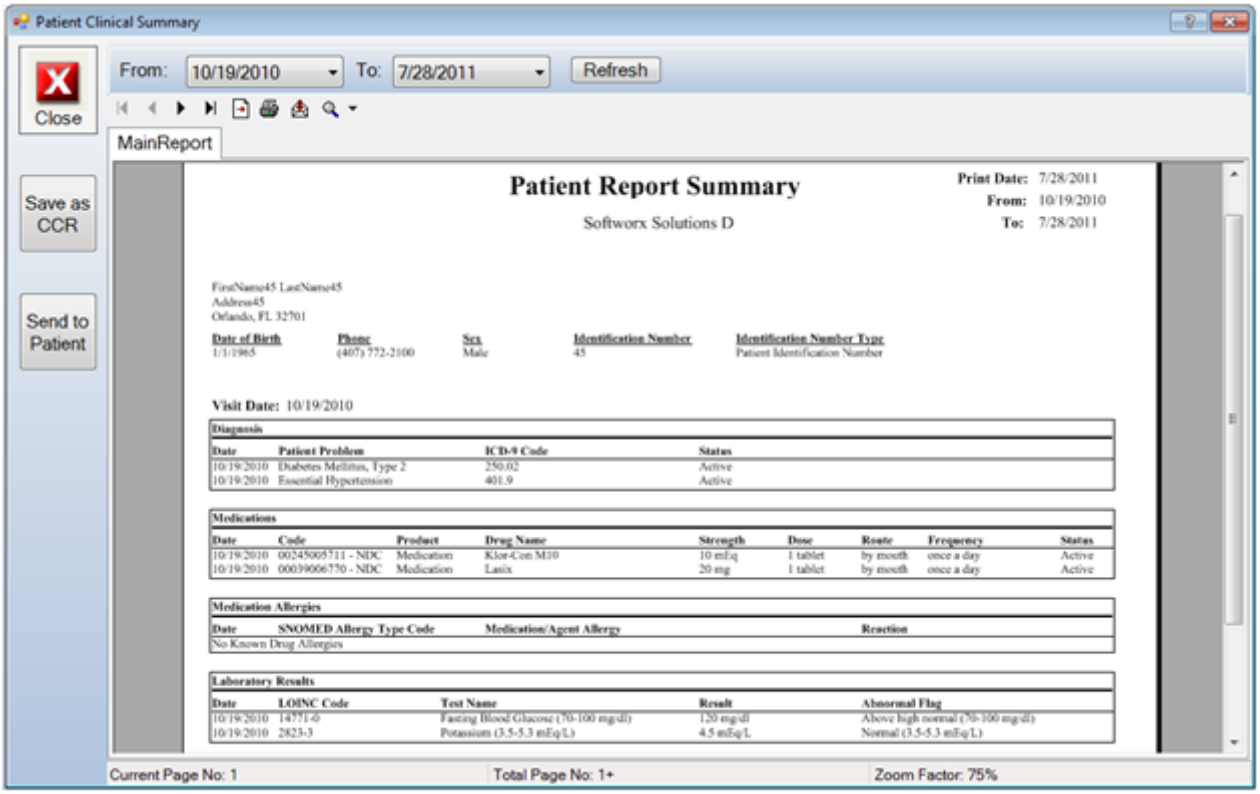
You must provide a summary care record for each transition of care or referral for more than 50 percent of transitions of care and referrals.

You can be excluded, if you have neither transferred a patient to another setting or you don't refer a patient to another provider during the reporting period.

In ChiroWrite, you can access the clinical summaries by navigating to Patient Activities > Clinical Summaries. This will allow you to run the patient's report shown below. First, you select a date range for which you want the reports run and click the search button.

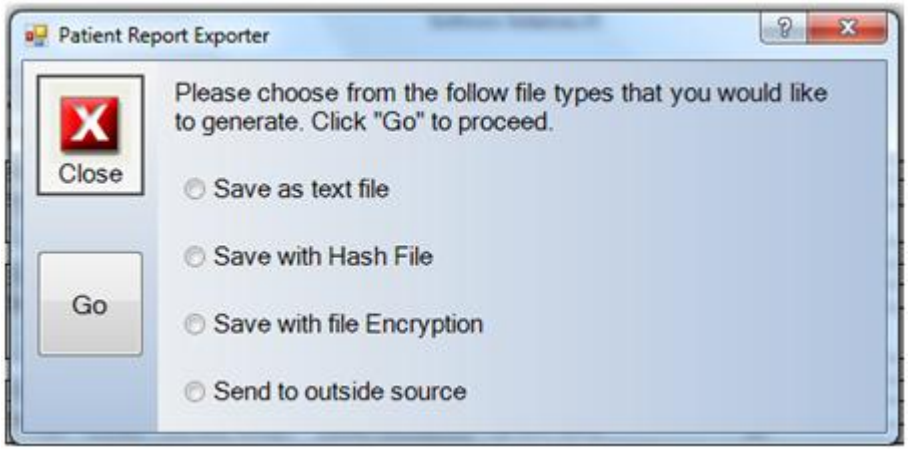


The reports can be printed out for patients to take with them to a new provider or sent directly to the Microsoft HealthVault so that the patient has electronic access to the same information, which they can also print themselves and take to the new provider. It can also be saved as an XML file by clicking on the Save as CCR button to allow it to be sent to another provider. For more information see the [Transition of Care Summary] video.

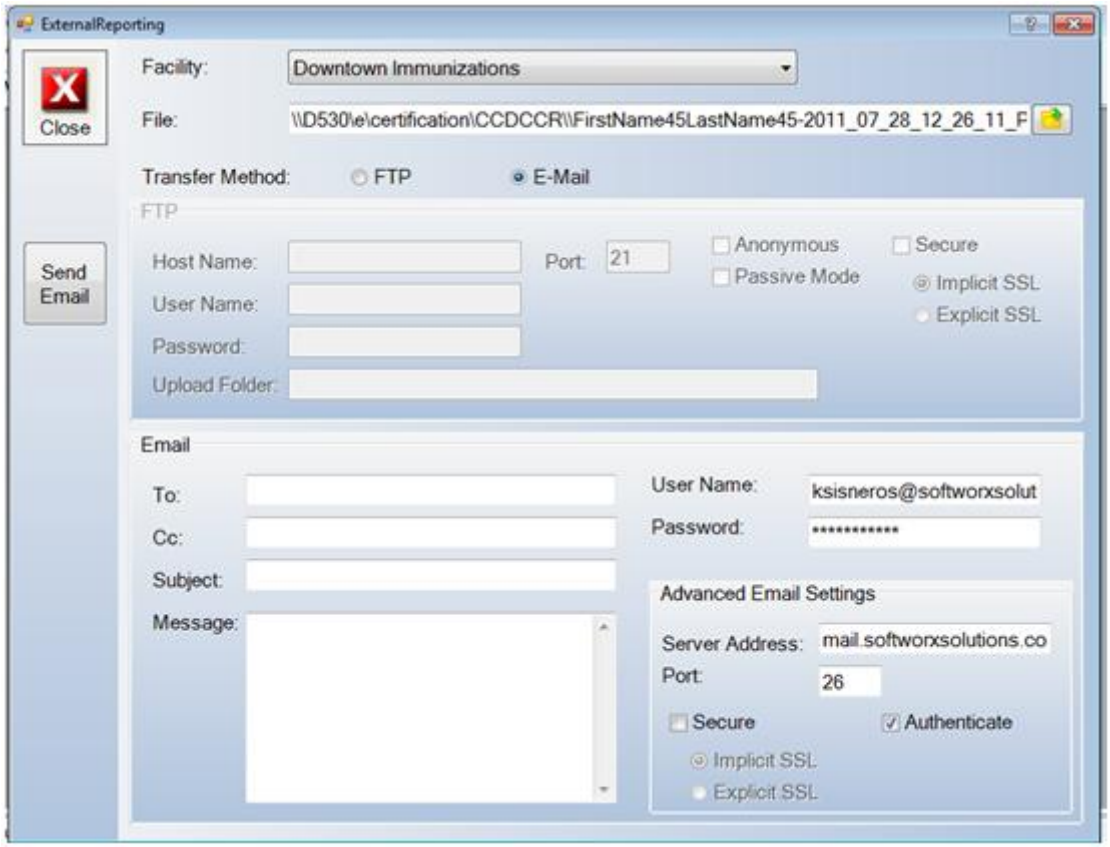


Clicking the print button will allow you to print the information for the patient. Clicking the Save As CCR button will allow you to save the file as text, with a hash code, save the file with encryption or send it

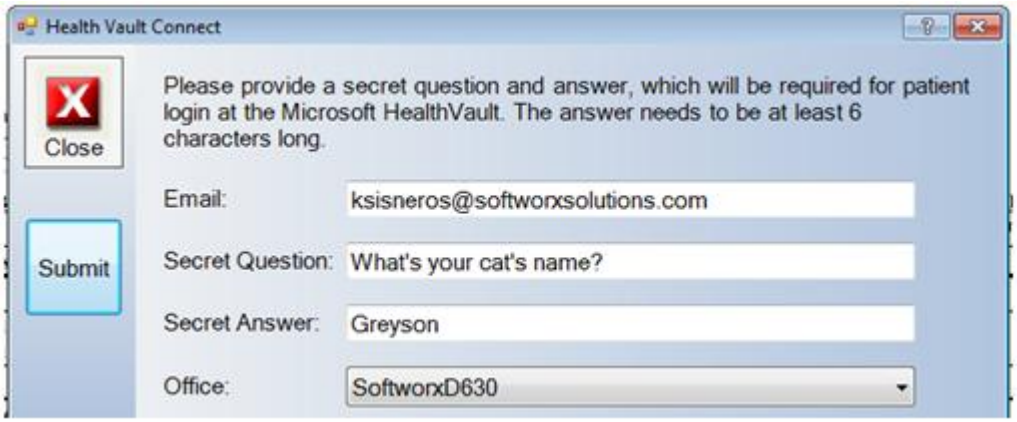
directly to an outside source.


Patient Report Exporter
Close
Please choose from the follow file types that you would like to generate. Click "Go" to proceed.
Save as text file
Save with Hash File
Go
Save with file Encryption
Send to outside source

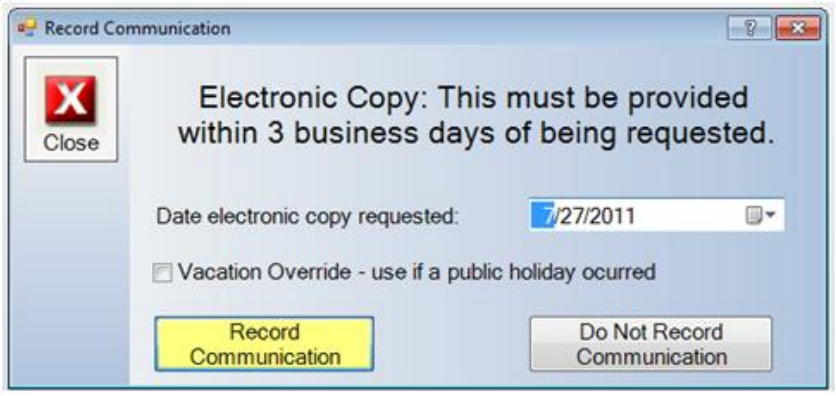
Sending to an outside source will allow you to securely FTP it somewhere or allow you to email it directly to someone. The individual you are sending the file to should have an application that can read XML documents otherwise the individual receiving the file will not be able to read the document.



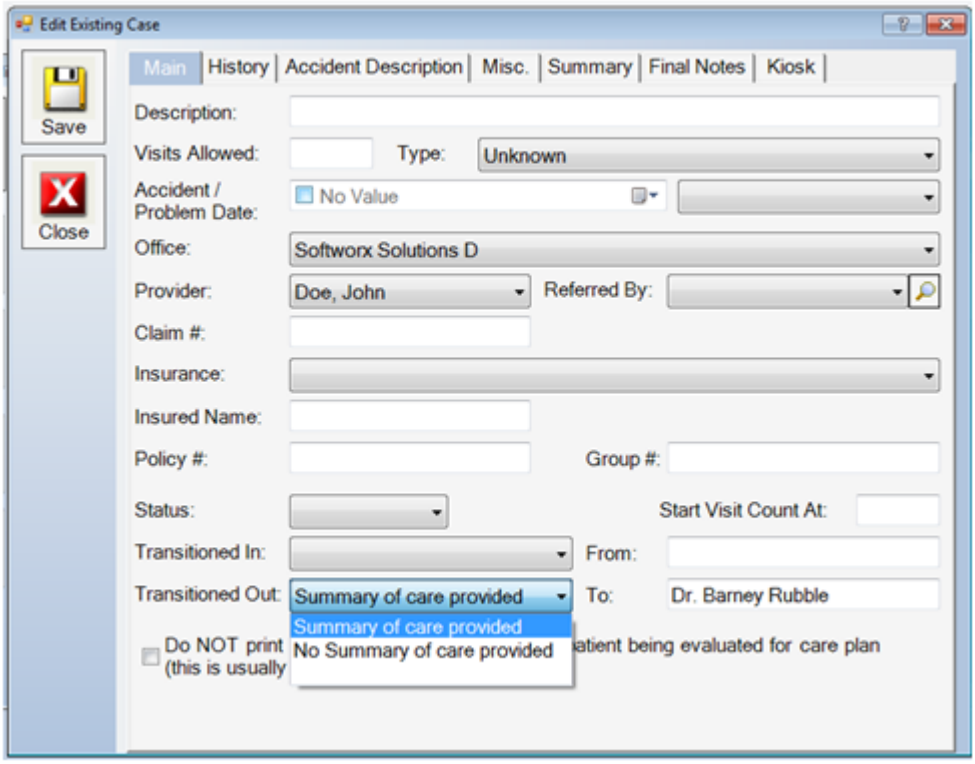
If you click the Send to Patient button the system will require some secret questions to be answered by the patient so that when they receive the email to get into the Microsoft HealthVault they are the only one with the information. Once you click the Submit button, the system will let you know if it successfully submitted the information to the HealthVault.



Once you have taken the necessary steps to send the information to the patient, the system will ask if you would like to record the communication. By recording the communication, ChiroWrite will be able to calculate whether or not you have taken the necessary steps to meet the measure.


Record Communication
Close
Electronic Copy: This must be provided within 3 business days of being requested.
Date electronic copy requested:
7/27/2011
Vacation Override - use if a public holiday ocurred
Record Communication
Do Not Record Communication

After you have chosen how the information is getting to the new provider, navigate to the case information and select summary of care provided from the Transitioned Out the drop down list. You can navigate to the case information either by selecting the doctor's bag ***and editing the case or selecting the yellow filing cabinet*** ***while in a note.***



Menu Measures 101

The following videos were created to help ChiroWrite users understand the menu measures and know what to do in ChiroWrite to complete them. The easier ones for chiropractors to complete have videos associated with them.

Keep in mind one of the two public menu measures have to be completed. Normally the syndromic surveillance data submission will be the one chiropractors report on.

Immunization Registries Data Submission
Syndromic Surveillance Data Submission

Then we would choose for additional measures from the ones below. Generally chiropractors will choose four of the measures that are highlighted blue and have videos associated with them as they are easier to complete.

Implement Drug Formulary Checks
Clinical Lab Test Results
Patient Lists
Patient Reminders
Timely Access
Patient Specific Education
Medication Reconciliation
Transition of Care Summary

Attestation

For more information about attestation, please click on the link below

https://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp

The attestation area can be found at the link below

https://ehrincentives.cms.gov/hitech/login.action

If you need the attestation guide, please click on the link below. It holds very valuable information and will show you step by step just how to complete the attestation process and what information is required or needed for each section.

http://www.cms.gov/EHRIncentivePrograms/Downloads/EP_Attestation_User_Guide.pdf

A. Stage One, eligible providers are required to attest that they have used an ONC-Certified EMR.
B. Eligible professionals must use the ONC-Certified EMR for at least 90 days in the calendar year, 2011, prior to attestation.
C. Attestation will occur online and you will need the CMS EHR Certification ID for ChiroWrite.

CMD EHR Certification ID

Request the "CMS EHR Certification ID" for ChiroWrite you will need this during the attestation process. No exceptions.

1. Visit the Certified Health IT Product List http://onc-chpl.force.com/ehrcert/
2. Choose Ambulatory Practice Type
3. Search for ChiroWrite
4. Add ChiroWrite to your cart and then click on Get CMS EHR Certification ID

This worksheet will assist you in what you need to give to the government.

Attestation Worksheet

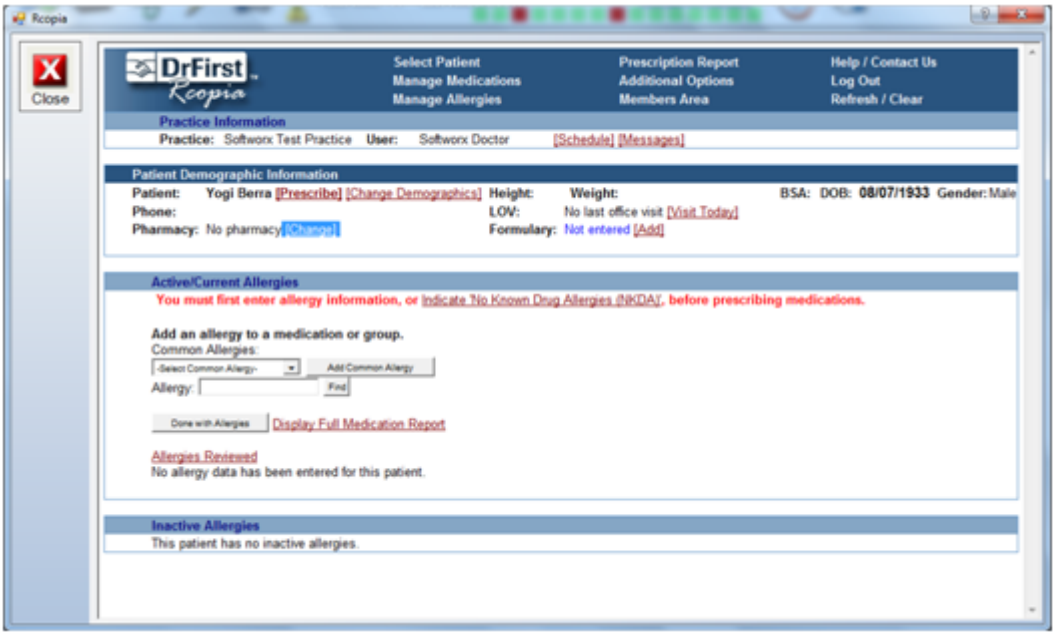
ChiroWrite does the calculations for you to enter in online, but attestation is the sole responsibility of the eligible professional.

Rcopia Help

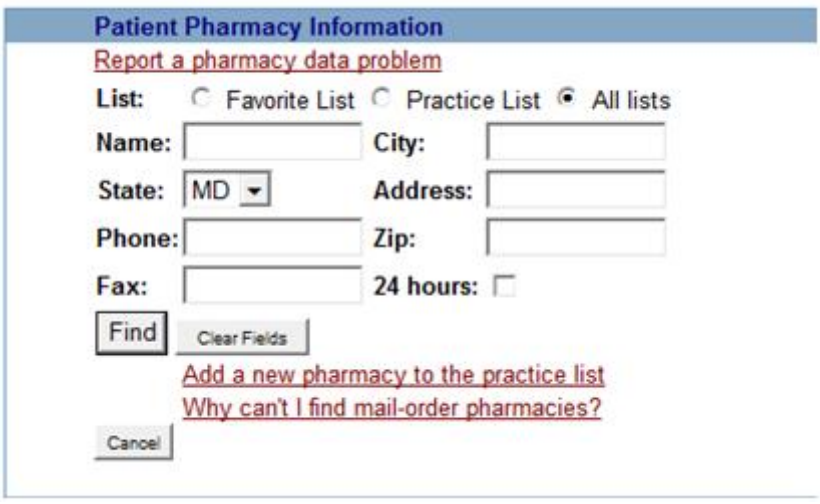
This section of the guide was created to assist you in using the external Rcopia portion of your certified EHR, ChiroWrite. Should you have additional questions or require assistance, please contact our office at 800.642.6082.

Selecting a Pharmacy: Rcopia

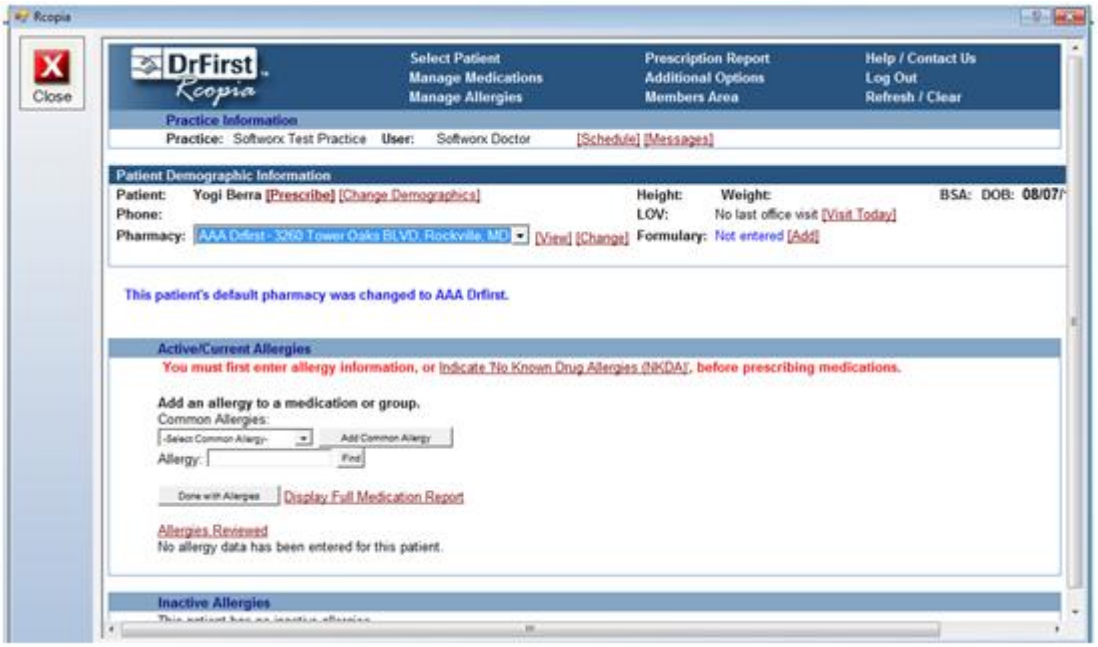
If you have not selected a pharmacy for a patient yet, then you must complete this action before entering in prescriptions for a patient. Navigate to Patient Activities > Patient Medications and click on the manage button to take you to Rcopia. Once in Rcopia, click on the change link just to the right of the area where it indicated no pharmacy has been selected for this patient.


Rcopia
Close
DrFirst Rcopia
Select Patient
Manage Medications
Manage Allergies
Prescription Report
Additional Options
Members Area
Help / Contact Us
Log Out
Refresh / Clear
Practice Information
Practice: Softworx Test Practice User: Softworx Doctor [Schedule] [Messages]
Patient Demographic Information
Patient: Yogi Berra [Prescribe] [Change Demographics] Height: Weight: BSA: DOB: 08/07/1933 Gender: Male
Phone: LOV: No last office visit [Visit Today]
Pharmacy: No pharmacy [Change] Formulary: Not entered [Add]
Active/Current Allergies
You must first enter allergy information, or Indicate 'No Known Drug Allergies (NKDA)', before prescribing medications.
Add an allergy to a medication or group.
Common Allergies:
Allergy:
Done with Allergies
Display Full Medication Report
Allergies Reviewed
No allergy data has been entered for this patient.
Inactive Allergies
This patient has no inactive allergies.

Now you will be able to search for a pharmacy that can be used to assist you in filling prescriptions for this particular patient.



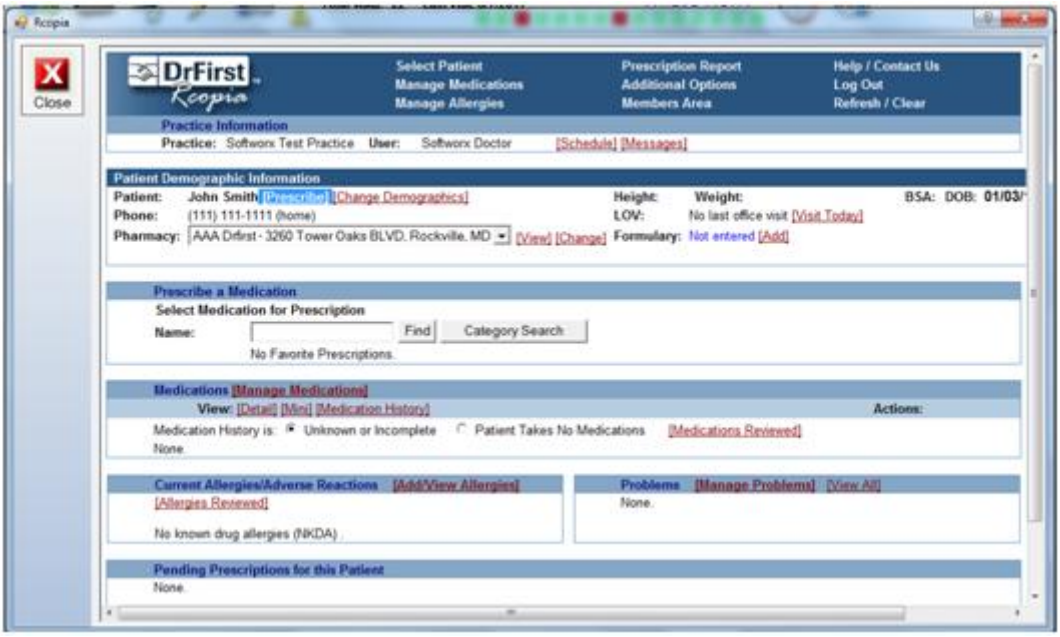
After searching for a particular pharmacy, as indicated to you by your patient, you may select this pharmacy from the list and use it for this patient. After selecting a pharmacy for your patient you will see it selected just under their name as shown below.


Rcopia
Close
DrFirst Rcopia
Select Patient
Manage Medications
Manage Allergies
Prescription Report
Additional Options
Members Area
Help / Contact Us
Log Out
Refresh / Clear
Practice Information
Practice: Softworx Test Practice User: Softworx Doctor [Schedule] [Messages]
Patient Demographic Information
Patient: Yogi Berra [Prescribe] [Change Demographics]
Height: Weight: BSA: DOB: 08/07/
Phone:
LOV: No last office visit [Visit Today]
Pharmacy: AAA Drfirst - 3260 Tower Oaks BLVD. Rockville, MD [View] [Change]
Formulary: Not entered [Add]
This patient's default pharmacy was changed to AAA Drfirst.
Active/Current Allergies
You must first enter allergy information, or Indicate No Known Drug Allergies (NKDA), before prescribing medications.
Add an allergy to a medication or group.
Common Allergies:
-Select Common Allergy-
Add Common Allergy
Allergy:
Find
Done with Allergies
Display Full Medication Report
Allergies Reviewed
No allergy data has been entered for this patient.
Inactive Allergies

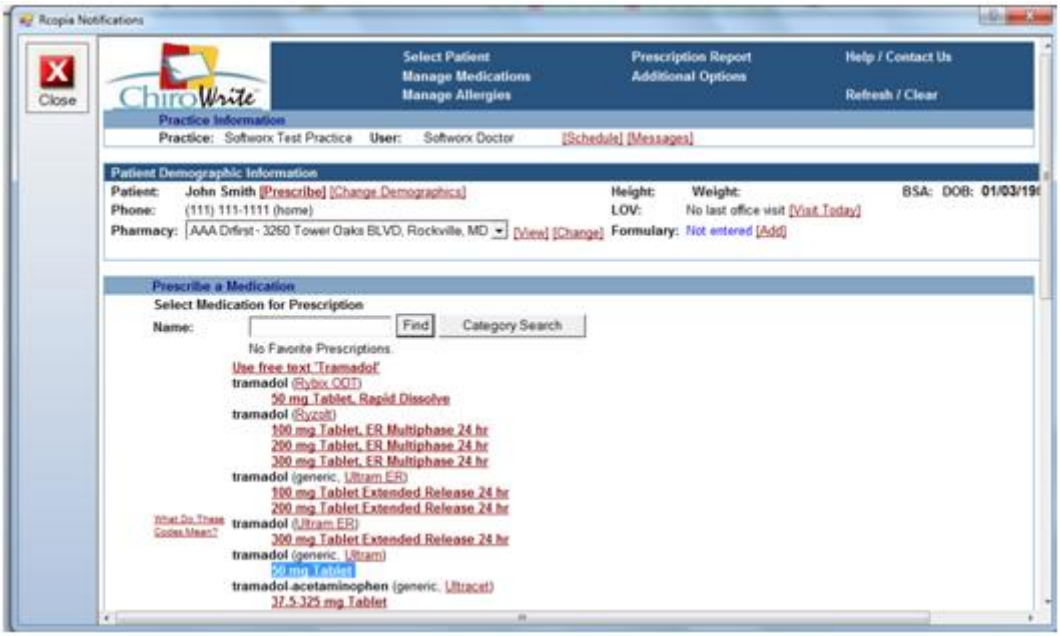
Prescription Writing: Rcopia

If you will be prescribing medications using Rcopia, this section will guide you through that process.

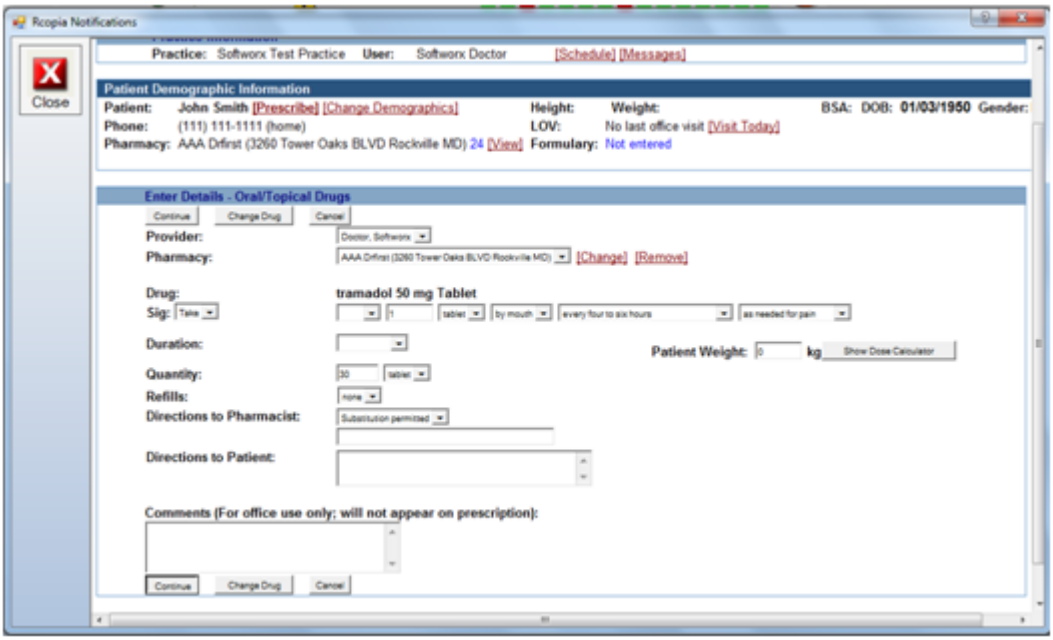
Prescriptions can be written by navigating to Patient Activities > Patient Medications and click on the manage button, this will take you to Rcopia. Once here, click on Prescribe just to the right of your patient's name. At this point you can begin prescribing medications and order them by sending to your patient's preferred pharmacy. Just be sure that a pharmacy is selected for your patient.



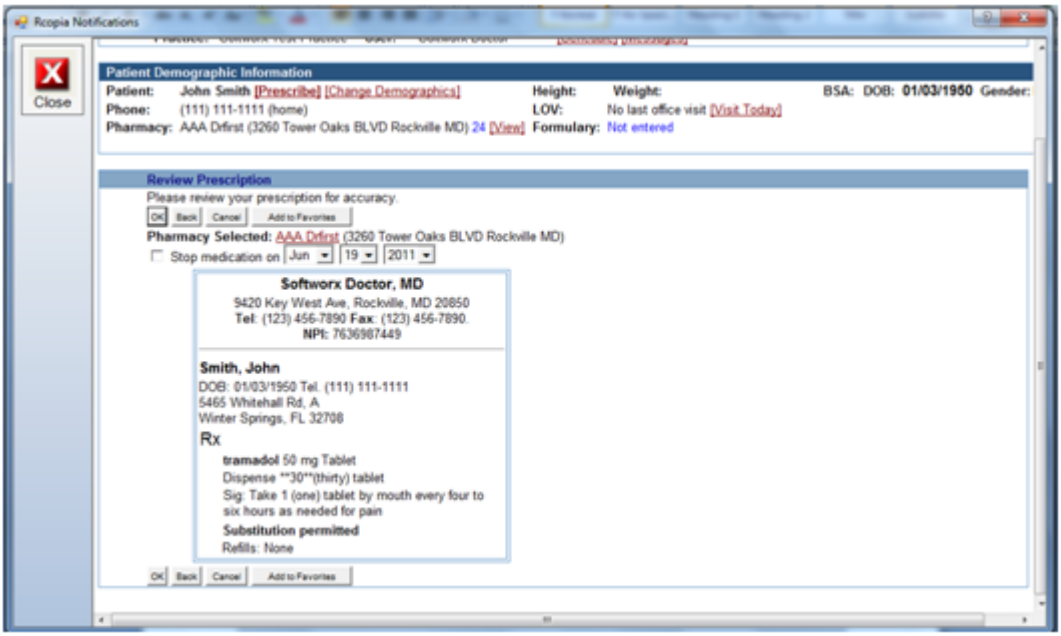
Type the name of a medication into the name field and click find to search for the medication you wish to prescribe. Be sure to then select the medication you are prescribing from the list as shown by the highlighted medication below.


Rcopia Notifications
Close
ChiroWrite
Select Patient
Manage Medications
Manage Allergies
Prescription Report
Additional Options
Help / Contact Us
Refresh / Clear
Practice Information
Practice: Softworx Test Practice User: Softworx Doctor [Schedule] [Messages]
Patient Demographic Information
Patient: John Smith [Prescribe] [Change Demographics] Height: Weight: BSA: DOB: 01/03/19
Phone: (111) 111-1111 (home) LOV: No last office visit [Visit Today]
Pharmacy: AAA Drfirst - 3260 Tower Oaks BLVD, Rockville, MD [View] [Change] Formulary: Not entered [Add]
Prescribe a Medication
Select Medication for Prescription
Name: Find Category Search
No Favorite Prescriptions.
Use free text 'Tramadol'
tramadol (Rybix ODT)
50 mg Tablet, Rapid Dissolve
tramadol (Ryzolt)
100 mg Tablet, ER Multiphase 24 hr
200 mg Tablet, ER Multiphase 24 hr
300 mg Tablet, ER Multiphase 24 hr
tramadol (generic, Ultram ER)
100 mg Tablet Extended Release 24 hr
200 mg Tablet Extended Release 24 hr
What Do These Codes Mean?
tramadol (Ultram ER)
300 mg Tablet Extended Release 24 hr
tramadol (generic, Ultram)
50 mg Tablet
tramadol-acetaminophen (generic, Ultracet)
37.5-325 mg Tablet

Now that the medication has been chosen, you need to give the patient some instruction about how and when to take this medication. Choose from the combination of drop downs and text boxes to enter information in regarding the instructions you wish to give the patient. When finished, click continue.


Rcopia Notifications
Close
Practice: Softworx Test Practice User: Softworx Doctor [Schedule] [Messages]
Patient Demographic Information
Patient: John Smith [Prescribe] [Change Demographics] Height: Weight: BSA: DOB: 01/03/1950 Gender:
Phone: (111) 111-1111 (home) LOV: No last office visit [Visit Today]
Pharmacy: AAA Drfirst (3260 Tower Oaks BLVD Rockville MD) 24 [View] Formulary: Not entered
Enter Details - Oral/Topical Drugs
Continue Change Drug Cancel
Provider:
Pharmacy: [Change] [Remove]
Drug: tramadol 50 mg Tablet
Sig:
Duration:
Patient Weight: kg
Quantity:
Refills:
Directions to Pharmacist:
Directions to Patient:
Comments (For office use only; will not appear on prescription):
Continue Change Drug Cancel

The patient's prescription will show up similar to the one below. At which point, you can click the OK button to proceed and continue what you are doing. Depending on who is logged in and how will depend on whether additional steps need to be take to sign and sent the script to the pharmacy.

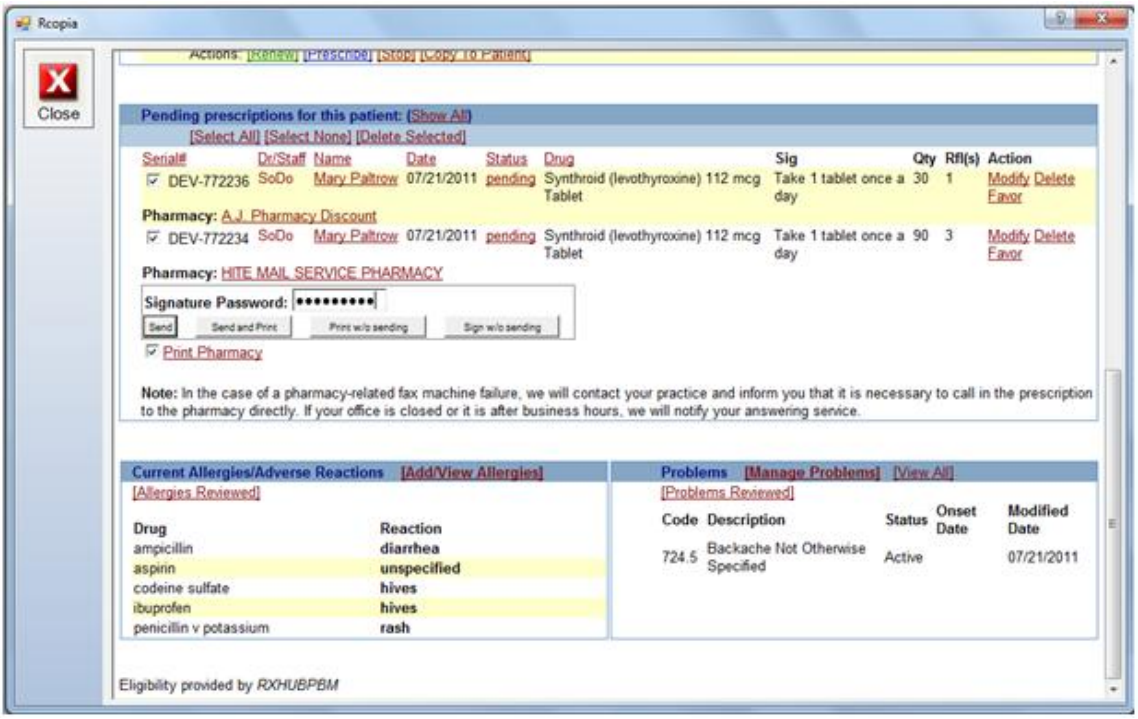

Rcopia Notifications
Close
Patient Demographic Information
Patient: John Smith [Prescribe] [Change Demographics]
Height: Weight: BSA: DOB: 01/03/1950 Gender:
Phone: (111) 111-1111 (home)
LOV: No last office visit [Visit Today]
Pharmacy: AAA Drfirst (3260 Tower Oaks BLVD Rockville MD) 24 [View]
Formulary: Not entered
Review Prescription
Please review your prescription for accuracy.
OK Back Cancel Add to Favorites
Pharmacy Selected: AAA Drfirst (3260 Tower Oaks BLVD Rockville MD)
Stop medication on Jun 19 2011
Softworx Doctor, MD
9420 Key West Ave, Rockville, MD 20850
Tel: (123) 456-7890 Fax: (123) 456-7890
NPI: 7636987449
Smith, John
DOB: 01/03/1950 Tel: (111) 111-1111
5465 Whitehall Rd, A
Winter Springs, FL 32708
Rx
tramadol 50 mg Tablet
Dispense **30**(thirty) tablet
Sig: Take 1 (one) tablet by mouth every four to six hours as needed for pain
Substitution permitted
Refills: None
OK Back Cancel Add to Favorites

Signing and Sending a Prescription: Rcopia

If you will be prescribing medications using Rcopia and sending them to the pharmacy electronically, this section will guide you through signing and sending the prescription.

Once a prescription has been written you have the ability to sign and send it to the pharmacy. The status of the prescription will let you know if it has been sent. If it has not been sent, then you will be able to enter in your signature password and choose from a variety of options.

The send button allows you sign and send the prescription to the pharmacy to be filled. The Send and Print button allows you to sign, send and print the prescription to be filled. The print without sending will allow you to sign and print the prescription without electronically sending it to the pharmacy. Sign without sending will allow you to sign the prescription, but not send it out to the pharmacy electronically and not print it


Rcopia
Close
Actions: [Renew] [Prescribe] [Stop] [Copy To Patient]
Pending prescriptions for this patient: (Show All)
[Select All] [Select None] [Delete Selected]
Serial# Dr/Staff Name Date Status Drug Sig Qty Rfl(s) Action
DEV-772236 SoDo Mary Paltrow 07/21/2011 pending Synthroid (levothyroxine) 112 mcg Tablet Take 1 tablet once a day 30 1 Modify Delete Favor
Pharmacy: A.J. Pharmacy Discount
DEV-772234 SoDo Mary Paltrow 07/21/2011 pending Synthroid (levothyroxine) 112 mcg Tablet Take 1 tablet once a day 90 3 Modify Delete Favor
Pharmacy: HITE MAIL SERVICE PHARMACY
Signature Password:
Send
Send and Print
Print w/o sending
Sign w/o sending
Print Pharmacy
Note: In the case of a pharmacy-related fax machine failure, we will contact your practice and inform you that it is necessary to call in the prescription to the pharmacy directly. If your office is closed or it is after business hours, we will notify your answering service.
Current Allergies/Adverse Reactions [Add/View Allergies]
[Allergies Reviewed]
Drug Reaction
ampicillin diarrhea
aspirin unspecified
codeine sulfate hives
ibuprofen hives
penicillin v potassium rash
Problems [Manage Problems] [View All]
[Problems Reviewed]
Code Description Status Onset Date Modified Date
724.5 Backache Not Otherwise Specified Active 07/21/2011
Eligibility provided by RXHUBPBM

Entering a Medication: Rcopia

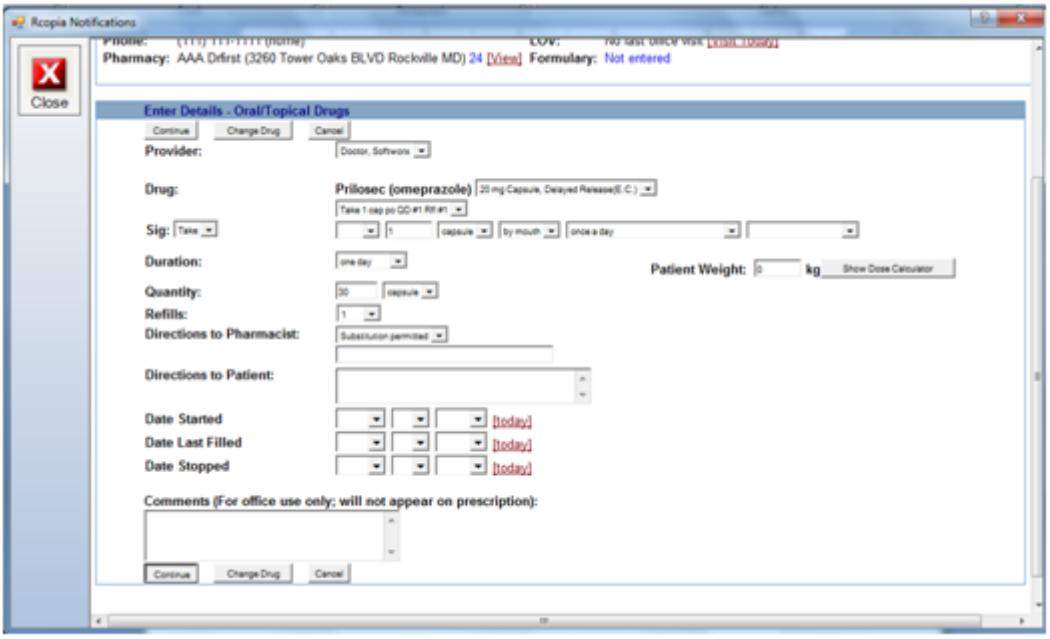
Entering a medication for the patient is also quite simple. In ChiroWrite, select a patient you wish to begin working with then navigate to Patient Activities > Patient Medications and click the manage button to begin using Rcopia. Select Manage Medications from the top blue bar, then begin typing a medication in the space provided. Click the find button when finished to begin searching for the medication you want to select for this patient.

Patient Medication Report
This screen is for viewing and modifying the patient's medication list, and adding medications that have been prescribed previously or elsewhere.
Add a medication:
Prilosec
Find
No Favorite Medications.

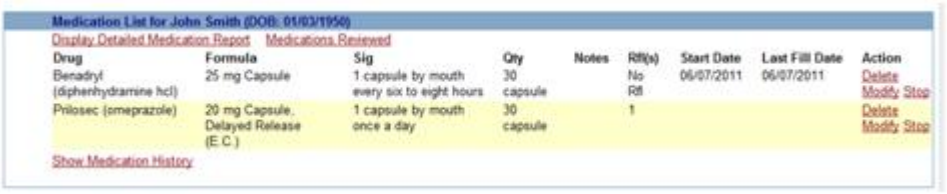
Find the correct medication complete with the correct dose you are selecting for this patient.

Rcopia Notifications
Close
ChiroWrite
Select Patient
Manage Medications
Manage Allergies
Prescription Report
Additional Options
Help / Contact Us
Refresh / Clear
Practice Information
Practice: Softworx Test Practice User: Softworx Doctor [Schedule] [Messages]
Patient Demographic Information
Patient: John Smith [Prescribe] [Change Demographics]
Phone: (111) 111-1111 (home)
Pharmacy: AAA Drfirst - 3260 Tower Oaks BLVD, Rockville, MD [View] [Change]
Height: Weight: BSA: DOB: 01/03/19
LOV: No last office visit [Visit Today]
Formulary: Not entered [Add]
Select Medication for Patient List
Select Medication for Medication List
Name:
Find
Category Search
Use free text 'Prilosec'
Prilosec (omeprazole magnesium)
2.5 mg Susp,Delayed Release for Recon
10 mg Susp,Delayed Release for Recon
Prilosec (omeprazole)
10 mg Capsule, Delayed Release(E.C.)
20 mg Capsule, Delayed Release(E.C.)
40 mg Capsule, Delayed Release(E.C.)
Prilosec OTC (omeprazole magnesium)
20 mg Tablet, Delayed Release (E.C.) (otc)
What Do These Codes Mean?
Medications [Manage Medications]
View: [Detail] [Min] [Medication History] Actions: [Renew Selected] [Select All] [Select None] [Check Interactions for Selected]
Medication History is: Complete Unknown or Incomplete [Medications Reviewed]

Now that the medication has been chosen, you need to give the patient some instruction about how and when to take this medication. Choose from the combination of drop downs and text boxes to enter information in regarding the instructions you wish to give the patient. On this screen, you are also able to choose a start date, a last filled date or a date stopped for previous medications. When finished, click continue.

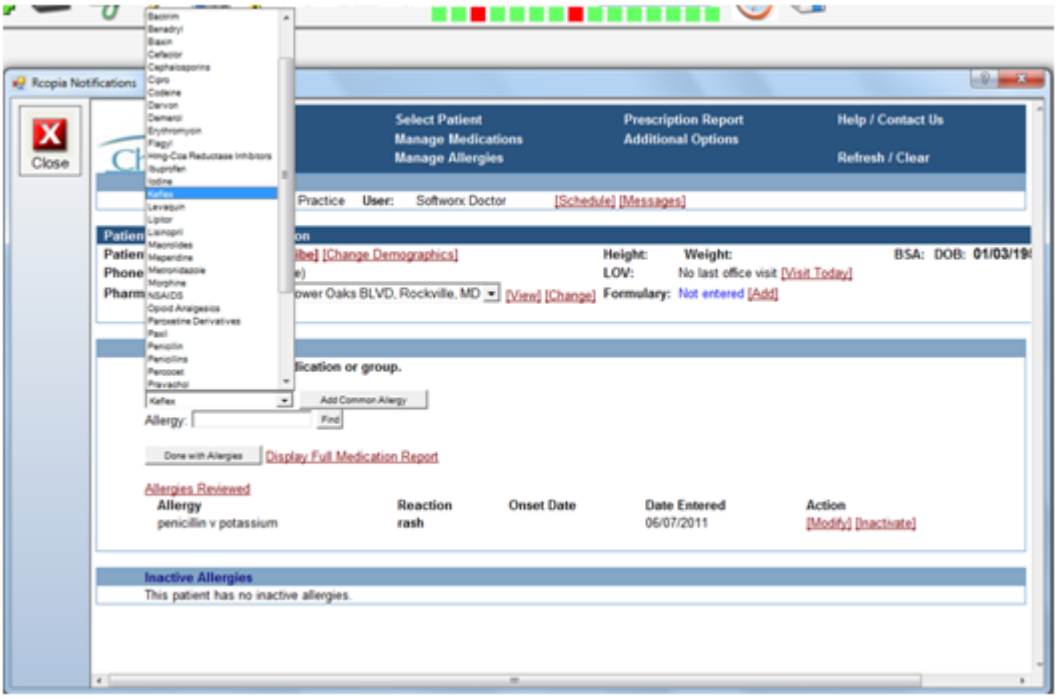


After you click continue, the medication will be added to the medication list for your patient.



Entering an Allergy: Rcopia

Entering an allergy for the patient is quite simple. In ChiroWrite, select a patient you wish to begin working with then navigate to Patient Activities > Patient Allergies and click the manage button to begin using Rcopia. Choose a drug allergy from the drop down list or begin typing in the space provided. Click the find button when finished to begin searching for the allergy you want to select for this patient.



Once you have selected the allergy you must then select the reaction that it causes. Complete this by using the drop down or simply type the reaction into the space provided. Click the add button when you are finished.